Assessment of Youth Reproductive Health Programs in Paraguay

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YouthNet Assessment Team

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About YouthNet

YouthNet is a global program committed to improving the reproductive health and HIV/AIDS prevention behaviors of youth 10-24 years old. YouthNet works to improve and strengthen youth programs, services, and policy, conduct research, and disseminate and promote information, tools, and evidence-based approaches that address reproductive health and HIV/AIDS prevention for youth at national, regional, and international levels. The program is funded by the United States Agency for International Development (USAID) through a five-year cooperative agreement awarded in October 2001 to Family Health International (FHI), in partnership with CARE USA and RTI International.

Through its efforts and strategic partnerships, YouthNet aims to achieve the following three results:

Result 1: Enhanced community and political support – Strengthened community support for youth reproductive health and HIV prevention programs. This includes interventions at the policy level, with mass media, and with community-based volunteer organizations, including faith-based groups.

Result 2: Improved knowledge, attitudes, skills, and behaviors – Enhanced capacity of the education sector to reach in-school and out-of-school youth with knowledge and skills needed to foster and sustain health-affirming behaviors.

Result 3: Greater access to quality products and services – Increased availability and quality of youth-friendly services and products to meet the reproductive health and HIV prevention needs of young people, including those who are most vulnerable.

To achieve these results, and meet the comprehensive and wide-ranging needs of young people, YouthNet provides technical assistance and carries out programs in countries where governments, USAID Missions, and other organizations express interest and need; conducts research to identify and evaluate evidence-based approaches and generate cutting-edge knowledge in youth reproductive health and HIV; disseminates and promotes state-of-the-art findings, materials, tools and curricula; and implements innovative programs and policies that enhance youth participation and leadership.

YouthNet focuses on a variety of technical areas, with specific expertise in sex education, peer education, reproductive health services for youth, and media and behavior change communication. The project also has four important cross-cutting themes, including gender, community involvement, youth participation, and policy. Monitoring and evaluation is integrated throughout the project's global, regional, and country-level programming to ensure that achievements towards program goals and objectives can be measured. YouthNet seeks to complement programs already being successfully implemented by identifying gaps, promoting sharing of information and skills, forging innovative partnerships, and helping to address unmet needs. As with other FHI programs, YouthNet's emphasis is on collaboration with local implementing partners and building the capacity and ownership of programs for sustainable interventions.

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Finally, we thank the many young people we had the privilege of meeting. We hope our efforts have an immediate and long-lasting impact on their improved health and well-being.

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
ARV	Antiretroviral
BECA	*Base Educativa y Comunitaria de Apoyo*
BCC	Behavior Change Communication
BSS	Behavioral Surveillance Survey
CAIA	*Centro de Atención Integral al Adolescente* (Center for Integrated Attention for Adolescents)
CASA	*Centro de Apoyo para la Salud del Adolescente* (Center for Support of Adolescent Health)
CDC	Centers for Disease Control and Prevention, US
CDIA	*Coordinadora por los Derechos de la Infancia y la Adolescencia* (Coordinator for the Rights of the Child and Adolescent)
CEPEP	*Centro Paraguayo de Estudios de Población* (Paraguayan Center for Population Studies)
CIRD	*Centro de Información y Recursos para el Desarrollo* (Center for Development Information and Resources)
CSP	Country Strategic Plan
ECP	Emergency Contraceptive Pill
ENDSSR	*Encuesta Nacional de Demografía y Salud Sexual y Reproductiva 2004* (National Demographic and Sexual and Reproductive Health Survey)
ENSMI	*Encuesta Nacional de Salud Materno Infantil 1998* (National Maternal Child Health Survey)
FHI	Family Health International
FUNSIA	*Fundación Salud Integral para la Adolescencia* (Foundation for Integrated Adolescent Health)
GTZ	German Technical Cooperation
HIV	Human Immunodeficiency Virus
IDB	Inter American Development Bank
IDU	Injecting Drug User
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
IPS	*Instituto de Previsión Social* (Social Security Institute)
IQC	Indefinite Quantity Contract
IUD	Intrauterine Device
MEC	*Ministerio de Educación y Cultura* (Ministry of Education and Culture)
MOH	Ministry of Health
MSM	Men who have Sex with Men
NGO	Nongovernmental Organization
PAHO	Pan American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	Person Living with HIV/AIDS
PRC	*Cruz Roja Paraguaya* (Paraguayan Red Cross)

PROMESA	*Promoción y Mejoramiento de la Salud* (Health Promotion and Improvement)
PRONASIDA	*Programa Nacional de Control de SIDA* (National AIDS Control Program)
PSI	Population Services International
SAIA	*Servicio de Atención Integral del Adolescente* (Integrated Adolescent Services)
SNIA	*Secretaría Nacional de la Infancia y la Adolescencia (*National Secretaríat for Children and Adolescents)
STI	Sexually Transmitted Infection
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YRH	Youth Reproductive Health

Executive Summary

Now in the early stages of developing a new Country Strategic Plan, USAID/Paraguay stands at an important juncture in deciding the nature and scope of its future support for youth reproductive health (YRH) efforts in Paraguay. The Mission requested YouthNet to carry out this assessment as input to the development of its new strategic plan, and to recommend adjustments to USAID's current activities.

Reproductive Health Situation. The assessment coincides with the release of new 2004 survey information heralding important positive changes in YRH status in Paraguay. Fertility rates for 15-19 year old girls of 65 per 1000 are now lower than in other countries in South America, and contraceptive use among women married or in union is 61 percent in the 15-19 age group and 71 percent in the 20-24 age group. Despite these encouraging advances, many challenges remain. Although age at first sex has remained unchanged over time, the vast majority of young women now have their first sexual experience outside of a stable union. Contraceptive use has risen, but many young women still use less effective, traditional methods. Meanwhile, HIV infection rates are low in the general population but the rates are significantly higher among vulnerable subgroups such as female sex workers, many of whom are youth. Moreover, knowledge of HIV prevention behaviors is quite low. Maternal mortality, at 170 deaths per 100,000 live births, remains troublingly high, and disproportionately affects adolescent girls.

Contextual Factors. The context within which Paraguayan youth mature contains several factors that influence these trends in reproductive health status and behaviors. Over 90 percent of young women now complete primary education, and almost half now complete secondary school, reflecting important advances over the past two decades. Increasing age at first marriage has helped to postpone first births, which generally occur within marriage. Recent positive changes in gender norms are a result of greater exposure to information, a more open atmosphere to hearing positive message on sexuality and reproductive health, and more equitable depiction of gender roles in the mass media. Nonetheless, many of these positive achievements have been unequally distributed across society. Poor and rural youth are much more vulnerable than their wealthier, urban counterparts. Moreover, poverty disproportionately affects young people, perpetuating poor health and lack of education and job opportunities.

Policy Environment. The policy environment for youth reproductive health contains both supportive and non-supportive elements. Paraguay enjoys a robust array of laws and policies that support YRH efforts, including a National Adolescent Health Plan and a comprehensive child and adolescent legal code. Few, if any, laws exist that impede the provision of reproductive health care to adolescents. Furthermore, Paraguay has established several important institutions that favor the development and implementation of supportive YRH policies and has an active civil society advocating for YRH programs. A flourishing private sector provides a range of choices for adolescents and youth with the money to seek products and services. Still, poor coordination among stakeholders, lack of participation by youth in policymaking, and chronic lack of resources have

hampered policy implementation. In part these weaknesses reflect the low priority the government and society as a whole gives to adolescent and youth issues. Moreover, although conservative and religious opposition to YRH efforts is relatively muted, such resistance continues to be an important brake on policy implementation.

Existing YRH Programs. The array of existing YRH programs in Paraguay is relatively limited and generally small in scope compared to many other countries. Very few USAID-funded cooperating agencies operate in the country and international technical assistance is limited. Nonetheless, programs exist in both the public and NGO sectors, and the private commercial sector remains a very important source of YRH care. Adolescent-specific clinical services were established in 1997 and different government and NGO models now operate in various parts of the country. Still, access to and quality of clinical care remains low, due to shortages of contraceptives, provider misinformation, inconvenient hours, and other problems. Peer education programs are widespread, and a broad consensus exists that such efforts are effective. Various groups use mass media — especially radio — to promote positive YRH messages. Nonetheless, resource constraints have limited promotion and outreach efforts, particularly to the poor and rural youth who are most in need of information and services. Contraceptives are widely available in pharmacies and other commercial retail outlets and are relatively affordable for young people given the competitive retail environment and the existence of social marketing brands. The public school curriculum includes sexuality and reproductive health education topics, but lack of teacher training and classroom materials have curtailed efforts to implement the sexuality education curriculum in schools.

Recommendations. Based on these findings, the assessment recommends three sets of actions to help close the gap between youth reproductive health needs and current programs. By supporting these activities, USAID can help Paraguay consolidate and build on recent significant improvements in YRH status.

<u>USAID-specific Recommendations – Short-term</u>

Access to Services. To reduce access barriers, USAID should support ***improving the skills of existing providers of adolescent clinical services*** through training on counseling and by updating technical expertise on contraception. Depending on interest, such training could also focus on making existing health services for adults more appealing and accessible for youth.

Access To Contraceptives. According to PROMESA, there is widespread leakage of USAID-donated oral contraceptives to pharmacies, in contravention of USAID policy and undercutting sales of socially-marketed brands. ***USAID should determine if steps taken to address the problem have been sufficient.*** USAID should also ***increase donation of condoms to PSI/Paraguay*** as a way to generate funds for the youth activities of PROMESA. Furthermore, to improve access and quality of services, USAID, in consultation with UNFPA, should look into ways to ***provide contraceptives for the existing adolescent centers that lack contraceptives.***

Sexual and Reproductive Health Education. Government authorities express interest in teacher training in sexual and reproductive health, but technical assistance and funding is lacking. USAID should ***identify and finance a local partner to undertake such teacher training and develop complementary sex education materials.***

*Communications/Mass Media***.** An important part of any overall attempt to improve youth reproductive health behaviors and outcomes is a communications strategy. ***USAID should spearhead the development of a national communications strategy for youth reproductive health,*** with the understanding that implementation of the strategy would likely await USAID support under the new Country Strategic Plan (CSP).

Policy Environment and Interagency Coordination. The National Reproductive Health Council is a relatively well-functioning organization that is in the vanguard of pushing for concerted and national action on reproductive health issues. USAID can strengthen the work of the Council in this area by ***encouraging the creation a committee dedicated to youth reproductive health*.** USAID can further act to improve interagency coordination and raise the quality of YRH services by ***encouraging the re-activation of the Technical Group on Adolescence*** contemplated in the current National Adolescent Health Plan.

Community/Parental Support. USAID can strengthen current community efforts by ***including YRH issues more comprehensively in the community work USAID supports under the Health Alliance project.*** Such work could build on existing projects and prioritize strengthening community youth groups and reaching young people with information through peer education and other means.

*Program Design/Evaluation/Research***.** Good information is critical to the design and evaluation of YRH programs. USAID ***should build on its current efforts through sponsorship of additional analyses of survey data*** including calculation of the median age at sexual debut, median age at marriage, source of contraceptives by age group, and health indicators for the 15-19 and 20-24 age groups broken out by socioeconomic quintiles. USAID should also address gaps in knowledge about male reproductive health behaviors through ***support for a qualitative study of adolescents 10-19, with emphasis on boys.*** Should the Mission go ahead with its intention to support a behavioral surveillance survey (BSS) that focuses on groups at high risk of HIV infection, it should ***ensure that the BSS adequately takes into account age factors recognizing that vulnerable groups (e.g. sex workers) are mainly young people under 25***.

<u>USAID-specific Recommendations – Long-term</u>

USAID has two long-term options for addressing youth reproductive health needs under its new CSP. The first option is to develop a stand-alone YRH project that would comprehensively address important gaps in the areas of service delivery, access to contraceptives, community outreach, sex education, and communications, while also working to facilitate a more favorable political and social context for YRH behaviors and programs. A second long-term approach is to mainstream a focus on poor, underserved

youth within each of the four strategic objectives that USAID is proposing under its new strategic plan: democracy, economic growth, health, and environment.

Additional Recommendations

Three additional recommendations cover activities outside the comparative advantage of USAID, but are priorities for improving youth reproductive health in Paraguay. These include (1) creating an academic specialization in adolescent health in the university faculties of medicine, psychology, nursing, midwifery, and social work; (2) providing antiretroviral drugs (ARVs) and contraceptives through the social security system; (3) providing contraceptives for the Adolescent Center at the Red Cross Hospital; and (4) assuring that technically accurate information on reproductive health is presented in all teacher training materials, and in all textbooks and classroom resource materials used by teachers to instruct students in reproductive health topics.

I. INTRODUCTION AND BACKGROUND

I.A. Context for the Assessment

As one of the few donors working on reproductive health issues and with its years of experience, the U.S. Agency for International Development (USAID) is in a strong position to continue providing valuable assistance to help Paraguay achieve its development aims. Moreover, USAID/Paraguay has historically recognized that adequately meeting youth reproductive health needs is critical to achieving social and economic progress and to reducing poverty in Paraguay. Under its current CSP and within its strategic objective to improve reproductive health conditions within the country, the USAID Mission has supported specific programs to improve the reproductive health of the 10-24 year old population. These include support for local nongovernmental organizations (NGOs) to provide information and services to in- and out-of-school youth and to rural adolescents.

The Mission now stands at an important juncture in deciding the nature and scope of future support for youth reproductive health efforts in Paraguay and is in the early stages of developing a new CSP. Under this CSP, the Mission expects to work in four areas: democracy, economic growth, health, and environment. These focus areas broadly match the priority development and poverty reduction strategies of the Paraguayan government.[1]

Encouraged by positive trends in many of the key reproductive health indicators including declining fertility rates, the Mission plans to de-emphasize the problem of rapid population growth in its next strategic plan and expand the range of activities supported under its emphasis on reproductive health to include family planning, maternal health, breastfeeding promotion, and HIV/AIDS prevention, care, and support. Paraguay is not one of the countries receiving assistance from the President's Emergency Plan for AIDS Relief (PEPFAR), thus limiting the Mission's access to HIV/AIDS funding. Nonetheless, USAID/Paraguay remains very interested in supporting basic research on the HIV/AIDS situation in the country — an area which is severely lacking — and thus contribute to a solid evidence base to guide the actions of the Paraguayan government and civil society.

The new strategy will also likely emphasize serving underserved populations and those at greatest risk of poor reproductive health outcomes. In Paraguay, those groups include poor people, those living in rural areas, and adolescents and youth. At this preliminary stage, the Mission has not decided whether its new CSP will have a specific geographic focus as does its current strategic plan.

USAID also recognizes that, by itself, it lacks the resources to make a major impact on the health sector. Thus, it hopes to tailor its support to have an impact in defined areas or to develop models that other donors or the government can replicate and scale up. One

[1] USAID/Paraguay. 2004. *Concept Paper for Proposed Strategic Plan, 2006-2011.*

possible avenue for achieving this goal is through greater policy engagement with central government officials. Currently, the Mission's efforts with the public sector have mainly focused on direct assistance to local and departmental governments and health authorities.

It is against this backdrop that the Mission requested YouthNet to carry out this assessment of youth reproductive health needs. The assessment aims to give guidance on how the Mission can focus on the 10-24 year old age group within the broader context of its country strategy. The findings and recommendations from this assessment aim to serve as input to the development of the new strategic plan, as well as to suggest adjustments to the set of activities supported under its current strategic plan. The assessment may also serve the needs of the broader group of stakeholders interested in improving reproductive health of young people in Paraguay.

I.B. Assessment Team Methodology

The assessment began before arriving in-country with team members identifying and reviewing key documents to understand the current state of youth reproductive health in Paraguay. This desk review covered documents from USAID/Paraguay and USAID cooperating agencies, UN and other international organizations, government ministries, and international and national NGOs.

The in-country phase of the assessment took place between November 29 and December 10, 2004. The team gathered information in-country through key informant interviews and site visits to identify how youth reproductive health (YRH) programs address the needs of youth at different life stages and in varying settings (e.g. rural/urban, in-school/out-of-school); the social and cultural context including family and community norms, the technical and program gaps and challenges; and stakeholder views on possible solutions to existing YRH problems.

Small group discussion with youth

The primary goal of the meetings with NGOs, government ministries, and donor agencies was to listen to what they are doing on the ground. Every meeting started with an introduction and overview of YouthNet as well as the purpose of the visit and included questions on what the organizations and individuals saw as the most critical problems and needs of youth, possible solutions, and priority areas for programs and services. The team also held small group discussions with two groups of youth to understand further the norms and practices among various communities in Paraguay. The

YouthNet assessment team organized its visits to existing programs according to the priorities set by USAID/Paraguay. Appendix 1 includes a full list of in-country contacts and organizations visited. Appendix 2 gives more detail on each of the main groups involved in youth reproductive health.

The team met with USAID/Paraguay staff on the first day of the assessment to review the scope of work and the planned meetings and activities, and to clarify expectations. The team met with USAID staff midway through the assessment to provide some preliminary feedback and to gain better understanding of specific issues. In a meeting with USAID on the final day of the assessment, the team debriefed the Mission with a presentation and discussion on the team's preliminary findings and recommendations.

During the first week, the team worked primarily in and around the capital, Asunción, and was able to meet with all the major organizations identified in consultation with USAID and to conduct site visits to clinics and other YRH programs. The second week included more meetings with officials as well as site visits to programs in two cities outside the metropolitan area of Asunción, Coronel Oviedo, and Villarrica. The two youth advisors on the team played key roles in organizing and leading small group discussions with youth in Asunción.

I.C. Report Structure

The report consists of two main sections: (1) findings and (2) recommendations. The findings section discusses priority youth reproductive health needs; the contextual factors that influence YRH behaviors, the policy environment for YRH programs, existing YRH programs, and donor assistance. Recommendations are organized according to those for USAID in the short-term (now through the end of its current strategy) and long-term (during the period of its new Country Strategic Plan) and additional recommendations for other donors and for the Paraguayan government and civil society. Appendices include a list of key informants, details on groups involved in YRH, a summary of the small group discussions, and a list of references, key documents, and Web sites.

II. FINDINGS

II.A. Reproductive Health Situation of Paraguayan Youth

The reproductive health status of Paraguayan youth – more properly the status of young women, given the lack of data on young men – has made great strides in the six years since the last national reproductive health survey in 1998. The results of the 2004 National Demographic and Sexual and Reproductive Health Survey (ENDSSR) conducted by the Paraguayan Center for Population Studies (CEPEP), with technical assistance from the U.S. Centers for Disease Control and Prevention (CDC), show large gains in important youth reproductive health indicators, particularly fertility and contraceptive use. In fact, the age-specific fertility rate for girls 15-19 is now lower (65/1,000) than that of Bolivia, Brazil, Colombia, Ecuador, and Peru, where recent comparable surveys have taken place.

USAID/Paraguay and other donors, the Ministry of Health, and local NGOs working in youth reproductive health deserve a lot of credit for the positive movement of many youth reproductive health indicators. Yet other indicators have not shown positive movement, such as early sexual activity by adolescent girls. Knowledge of HIV prevention behaviors is quite low, and the incidence of sexually transmitted infections among youth is unknown, but syphilis is estimated to be at epidemic proportions in the country, particularly affecting sexually active youth. Maternal mortality in the country is also high, and disproportionately affects adolescent girls who get pregnant. The incidence of abortion (illegal in the country except to save the mother's life) among adolescents and young women is another unknown, but is perceived to be a major problem that accounts for a significant percentage of the maternal mortality in the country. Approximately one fifth of the maternal deaths in the country in 2003 are due to abortion.[2] Finally, the reproductive health situation of adolescent boys and young men is largely unknown in the country aside from a quantitative study of out-of-school youth in Asunción and some qualitative studies.

Some of the key reproductive health indicators for Paraguayan youth are presented below. All data are from the 2004 ENDSSR unless otherwise noted.

II.A.1. *Sexual Activity*

As can be seen in Table 1 below, the median age of sexual initiation is between 18 and 19 years of age. There has been a slight increase in sexual activity among adolescent girls from 1998 to 2004. It is important to note that over 90 percent of women have their first sexual experience outside of marriage. This percentage is increasing over time given the steadily increasing median age of marriage in the context of a slighting decreasing age of sexual initiation.

Overall, 26 percent of adolescent girls 15-19 are currently sexually active (defined as having sex in the past three months), according to the 1998 ENSMI Survey. For young women 20-24, the figure was 59 percent.

Table 1. Sexual Activity Among Paraguayan Adolescent Girls and Young Women, 1998 and 2004

Percentage of adolescents/young women who have had sexual relations:	1998	2004

[2] Ministry of Public Health and Social Welfare. 2004. *Comisión Nacional de Vigilancia Epidemiológica de la Salud y la Mortalidad Materna: Informe del Año 2003*.

15-17	20	22
18-19	57	58
20-22	73	76
23-24	89	90
Percentage of adolescents/young women who have had sex in the last three months:	1998	2004
15-19 overall	26	N.A.
--married/in union	97	N.A.
--not in union	13	N.A.
20-24 overall	59	N.A.
--married/in union	97	N.A.
--not in union	22	N.A.

II.A.2. *Fertility*

Age-specific fertility rates have dropped substantially over the past six years as shown in Table 2 below. The median age of first pregnancy is between 23-24 years of age. Compared to other countries in South America where similar surveys have been conducted (Bolivia, Brazil, Colombia, Ecuador, and Peru), Paraguay has the lowest fertility rate among girls 15-19, and is in the middle in terms of fertility among 20-24 year old women (lower than Ecuador, Brazil, and Bolivia, but higher than Peru and Colombia).

Table 2. Patterns of Fertility for Paraguayan Youth, 1995-1998 and 2001-2004

Fertility rate (births per 1,000 women):	1995-1998	2001-2004
15-19	90	65
20-24	206	150
Percentage of adolescents/youth women who have had at least one pregnancy:	1998	2004
15-17	8	5
18-19	34	21
20-22	50	38
23-24	77	61

II.A.3. *Contraceptive Use*

As seen in Table 3 below, a large increase in contraceptive prevalence occurred over the last six years among women who were married or in union. It is important to note, however, that the percentage of women 15-19 who are married or in union is only 11 percent, and 41 percent for women 20-24. Among sexually active women 15-24 who were not married or in union, 83 percent used a method of contraception compared to 56 percent of married women 15-24 (1998 survey).

As Table 3 shows, traditional methods of contraception such as withdrawal and the rhythm method make up a significant portion of overall prevalence. Given the

unreliability of these methods, it is important to note the prevalence of modern methods when analyzing the prevalence of contraception among youth.

The most common method used by married/in union women 15-19 and 20-24 was the pill, followed by injectables. Condoms are the third most common method used by married/in union women 15-19, while IUDs are the third most common method used by married/in union women 20-24. For sexually active women not in union, condoms are the most common method of contraception for both age groups.

The ENDSSR preliminary report does not present contraceptive source by age group. However, because pharmacies are the leading source of contraceptives for the majority of women overall, it is likely that adolescents and young women also predominantly use pharmacies as their source for nonclinical methods. IUDs are primarily obtained from public sector providers.

While contraceptive prevalence among currently married women showed impressive gains between 1998 and 2004, use of contraception among women in their first sexual relation (over 90 percent of which was premarital) showed an even greater increase, from 31 percent to 56 percent.

Table 3. Young People's Use of Contraception in Paraguay, 1998 and 2004

Percentage of women married/in union using a contraceptive method:	1998	2004
15-19	42	61
20-24	57	71
Percentage of currently married women using a modern method of contraception:	1998	2004
15-19	36	48
20-24	52	62
Percentage of women, 15-24, who used contraception in their first sexual relation:	31	56
Percentage of sexually active women, 15-24, who used contraception in their last sexual relation:	1998	2004
Married/in-union	56	N.A.
Unmarried/not in-union	83	N.A.

II.A.4. *Maternal Mortality*

The maternal mortality ratio in Paraguay is estimated to be 170 per 100,000 live births.[3] The Ministry of Health reported 151 maternal deaths in 2003, of which 24 corresponded to girls 15-19.[4] The 24 adolescent maternal deaths were a 71 percent increase from the year before, when only 14 adolescent maternal deaths were reported. Examining the

[3] UNAIDS. 2004. *Paraguay. Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2004 Update.*

[4] Ministry of Public Health and Social Welfare. 2004. *Comisión Nacional de Vigilancia Epidemiológica de la Salud y la Mortalidad Materna: Informe del Año 2003*.

number of maternal deaths by age group underscores the high risk of maternal mortality posed by adolescent pregnancies. If maternal mortality were distributed evenly across age groups, one would expect there to be over twice as many maternal deaths to women 20-24 as to women 15-19, given their age-specific birth rates. Yet there were only 25 maternal deaths to women 20-24 years of age in 2003, compared to 24 maternal deaths among the 15-19 year old age group. This is consistent with worldwide data showing that girls 15-19 are twice as likely to die in childbirth as are women in their 20s.

Overall causes of maternal deaths in 2003 were hemorrhage (principal cause), followed by sepsis, abortion, toxemia, and other causes. A contributing factor for many of these maternal deaths is the lack of professional obstetrical care when problems arise. Only 74 percent of births take place in health facilities in Paraguay and not all of these facilities have emergency obstetrical care services available.

II.A.5. *HIV and STIs*

The HIV epidemic in Paraguay is a concentrated one, where the seroprevalence is less than one percent in the general population but greater than five percent in selected subgroups. According to a UNAIDS report, there were approximately 15,000 HIV positive adults (15-49) at the end of 2003, with an estimated adult national prevalence of 0.5 percent (with high/low estimates ranging from 0.8 percent to 0.2 percent). The same report notes that, according to the Ministry of Health, 40 percent of AIDS cases are due to heterosexual transmission while 34 percent are due to men having sex with men (MSM). The remaining cases are causes by blood transfusions, mother-to-child transmission or of unknown origin. Passive AIDS case surveillance is conducted in the country, with significant underreporting and delays, according to UNAIDS. The annual incidence rate is 2.5 per 100,000 population and the male/female ratio is 2:1.[5]

There is a dearth of data on HIV prevalence among adolescents and young adults. However, the National AIDS Control Program (PRONASIDA) reported to the assessment team that a national prevalence study would take place in 2005 that will hopefully provide further data on the extent of HIV among youth. PRONASIDA considers youth one of four vulnerable groups for HIV, along with MSM, injecting drug users, and female sex workers. Among the 671 cases of HIV/AIDS reported to the Ministry of Health between January 2000 and September 2002, 36 cases (five percent) corresponded to adolescents 10-19 years of age.[6]

UNAIDS estimates a high prevalence of sexually transmitted infections (STIs) in all populations. The low incidence estimated in 2002 (2.5 per 100,000 habitants) seems to be related to an elevated underreporting, reporting delays, and lack of reagents for diagnosis. STI studies in specific groups such as pregnant women, sex workers, and MSM revealed that the problem is broad and has not improved over the years. Syphilis prevalence

[5] UNAIDS. 2004. *Paraguay. Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2004 Update.*
[6] Ministerio de Salud Pública y Bienestar Social. 2002. *Plan Nacional de Salud Integral de la Adolescencia, 2002-2006.* Asunción: Ministerio de Salud.

among pregnant women, sex workers, and MSM was 6.3 percent, 37.4 percent, and 39 percent respectively. Between January 2002 and April 2003, five percent of 3,765 pregnant women aged 15-44 years tested positive for syphilis in the Hospital Barrio Obrero (Asunción). Since 2002, the country has been carrying out an emergency plan to eliminate congenital syphilis.

The 2004 ENDSSR includes a section on HIV/AIDS and STIs for the first time and Table 4 presents selected data below. Overall, young people's knowledge of how to prevent HIV/AIDS is quite low, with use of condoms being the most common preventive measure mentioned (through spontaneous recall, without prompting). Young people's perception of personal risk is also rather low. This is consistent with information the assessment team gathered in its discussion with youth representatives of youth-serving organizations, who report that pregnancy is a greater concern for young people than is HIV/AIDS.

Table 4. Young Women's Knowledge of Ways to Prevent HIV and Perception of Personal Risk of HIV Infection, Paraguay 2004

Percentage of adolescents/young women with knowledge of forms of HIV/AIDS prevention:	15-19	20-24
Avoid sexual relations	18	16
Have only one sexual partner	10	13
Use condoms in all sexual relations	35	37
Knowledge of all three forms of prevention	2	3
Percentage of adolescents/young women with perceived personal risk of becoming infected with HIV	15-19	20-24
Some risk/moderate	13	20
Much risk/large	1	1
No risk	84	77

II.A.6. *Sexual Coercion/Violence*

Another aspect of reproductive health that the 2004 ENDSSR analyzed for the first time was the prevalence of forced sex and physical violence among women 15-44 years of age. Experts believe that survey data on domestic and sexual violence substantially underestimates the problem, because women are often embarrassed or fear that a family member may overhear an answer given to a survey worker that they have otherwise kept secret. The assessment team's informants from *Base Educativa y Comunitaria de Apoyo* (BECA) – a local NGO working with victims of sexual and domestic violence – also considered the ENDSSR data on physical and sexual violence to be a significant underestimate of the magnitude of the problem.

For a point of comparison, the 2001 Youth Reproductive Health Screening Survey, conducted by the CDC among U.S. youth, found that 10 percent of females reported they had experienced physical violence by their boyfriend in the last year. The same survey found that over seven percent of students in the 9th, 10th, and 11th grades reported that someone had physically forced them to have sex when they did not want to.

The data in Table 5 below presents the main findings on the prevalence of physical and sexual violence towards adolescents and young adult women.

Table 5. Physical and Sexual Violence towards Paraguayan Adolescents and Young Women, 2004

Percentage of ever-married/in-union adolescents/young women who have suffered physical or sexual violence from their spouse, partner, or boyfriend:	15-19	20-24
Physical violence	18	20
Sexual violence	10	5
Physical violence in last 12 months	12	5
Sexual violence in last 12 months	9	2
Percentage of adolescents/young women who have ever been forced to have sex against their will:	4	5

II.A.7. *Summary*

Overall, the reproductive health status among young women is improving, yet in a few areas no improvement has occurred, and in many more areas information is lacking. The following bullets summarize the positive and negative trends discussed above, and note the areas where more information is needed to ascertain the true magnitude of the problem and whether it is getting better or worse.

Positive Trends

- Falling fertility rates among adolescents and young women
- Rising contraceptive prevalence among adolescents and young women
- Increasing use of contraception at first sex

Stagnant/Negative Trends

- Low age at first sex
- High rates of adolescent maternal mortality

More Information Needed

- Current sexual behaviors among youth
- Risky sexual behaviors among youth
- Sexual activity among adolescent boys and young men
- Condom use among adolescent boys and young men
- HIV prevalence among youth
- Incidence of other sexually transmitted infections (STIs) among youth
- Age distribution of HIV vulnerable subgroups
- Physical/sexual violence among adolescents and young women

II.B. Contextual Factors

Paraguayan youth, like young people everywhere, mature within a many-layered context that shapes the reproductive health status and behaviors described above. This context harbors factors that either decrease (protective factor) or increase (risk factor) the chances that a young person will have unhealthy behaviors. They operate at the individual, family, institutional, and community level and include feelings of self-efficacy, attitudes and behaviors of friends, connectedness with parents and other influential adults, and involvement in the community. They also include educational attainment, employment, marriage, and socioeconomic status, among others.

Although no formal study exists of these contextual factors and their influence on youth reproductive health in Paraguay, inference from existing data and interviews point to several factors that stand out in Paraguay and correlate to the worldwide evidence on protective and risk factors.[7]

II.B.1. *Educational opportunity*

Paraguay has made important recent strides in expanding educational opportunities. According to the 2004 ENDSSR survey, over 90 percent of women aged15-19 completed primary education through grade 6, compared to just 66 percent of women 40-44 years old. Similarly important advances in secondary school enrollment and completion for girls have also occurred, with women ages 20-24 twice as likely to have completed secondary school as compared to women ages 40-44 (52.5 percent versus 26.5 percent). According to data from UNESCO, girls are equally likely to attend primary school as boys and have slightly higher rates of school attendance than boys at the secondary level.[8] Such positive trends buttress the protective factor that formal education provides with respect to YRH behaviors and outcomes. In Paraguay, as in most other countries, educational achievement correlates strongly with better reproductive health status and outcomes. For example, fertility rates among women 20-24 who have not completed primary education are almost three times as high as those who have completed secondary school, 249 per 1000 versus 89 per 1000, according to the 2004 ENDSSR. The important strides the country is taking in the area of education reform also bode well for continuing these positive trends. Because of these educational gains, literacy rates are quite high, with over 95 percent of young men and women age 15-24 literate.[9]

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[7] For a full treatment of the literature on risk and protective factors see Blum, Robert and Kristin Mmari. 2004. *Risk and Protective Factors Affecting Adolescent Reproductive Health in Developing Countries. An Analysis of the World's Literature 1990-2004*. *Summary.* World Health Organization, Geneva.
[8] UNESCO. 2004. *Education Statistics.* Accessed December 20, 2004 from www.uis.unesco.org.
[9] UNESCO. 2004. *UNESCO Institute for Statistics - Country Profile: Paraguay*. Accessed December 20, 2004 from www.uis.unesco.org/countryprofiles.

These overall gains nonetheless mask some stark inequities in school access and attainment. School dropout beyond primary school remains a large problem for students from poor and rural families. This leaves many students with relatively few life choices and exposing them to greater risk of early and unwanted pregnancy. Moreover, the quality of schooling remains low, leaving many students who do complete school unprepared for becoming full and productive members of Paraguayan society.[10]

II.B.2. *Marriage Patterns and Social and Gender Norms*

Marriage norms in Paraguay are both a protective and a risk factor for reproductive health behaviors. Data from the 1998 ENSMI and 2004 ENDSSR surveys show that age at marriage appears to be steadily increasing; between 1995/96 and 2004, the percentage of 20-24 year-olds married or in union fell from 56 percent to 41 percent. Similarly, the percentage of 15-19 year old women married or in union dropped from 16 percent in 1995 to 11 percent in 2004. Increasing age at marriage provides some protection by postponing first births, which (as discussed above) generally occur within marriage. Nonetheless, the increasing gap between age at first sex and age at first marriage puts more young women at risk. High and increasing rates of premarital sex raise the chances of unplanned, unwanted pregnancies. This may have negative consequences in the form of higher rates of clandestine abortion and resulting maternal illness and death.

Other social norms that increase risk include peer pressure to have sex at an early age, especially for boys, and double standards that encourage boys to have sex while discouraging girls. A corollary of this double standard is the anecdotally reported practice of encouraging boys to have their first sexual experience with a prostitute. A still strong, albeit diminishing, culture of machismo underlies unequal gender relations and puts girls and young women at a disadvantage in negotiating sexual relations and condom use.[11]

The high reported rates of domestic violence and sexual abuse (see section above) also are a considerable risk factor for many young people. International evidence supports a strong correlation between such problems and later high-risk behavior by young people either when it comes to risky sex, or substance abuse, and physical violence and mental health problems.[12] Although Paraguayan youth report rates of tobacco and alcohol use comparable to neighboring countries, their use of injecting drugs is low.[13]

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[10] World Bank. 2003. *Project Information Document for Paraguay Secondary Education Reform Project.*
[11] See Aguilar, Patricia and Maria Santander. 1998. *Percepciones y opiniones de estudiantes universitarios asuncenos sobre masculinidad.* Catholic University of Asunción; Centro Paraguayo de Estudios de Población (CEPEP), MSP & BS, EngenderHealth, and USAID. 2001. *Necesidades y Perspectivas de Servicios de Salud Reproductiva para Hombres;* and González, Ariel. 2004. *Praxis en las Masculinidades. Experiencias Regionales—Paraguay.* Unpublished paper prepared for the Regional Workshop on Masculinity, Bolivia, November 2004.
[12] International Family Planning Perspectives. 2004. *Special issue examining violence and sexual abuse, Editors' Note.* Volume 30, Number 4, December 2004.
[13] Dirección General de Estadística, Encuestas y Censos (DGEEC). 2003. *Juventud en Cifras. Difusión de Información Cuantitativa sobre la Juventud.* Asunción: DGEEC; Ministerio de Salud Pública y Bienestar Social. 2002. *Plan Nacional de Salud Integral de la Adolescencia, 2002-2006.* Asunción: Ministerio de Salud.

II.B.3. *Exposure to Information*

Recent positive changes in gender norms are a result of greater exposure to information, a more open atmosphere to hearing positive message on sexuality and reproductive health, and more equitable depiction of gender roles in the mass media. According to the 2004 ENDSSR, access to radio and television are high, with almost 90 percent of households surveyed in 2004 having both a radio and a television. Radio in particular is influential among rural and poor youth. Moreover, over half of households have a cell phone, including 31 percent of rural households. By contrast, Internet access is currently very low; with 3.3 Internet users per thousand population, Paraguay ranks last of 165 countries.[14] Almost all young people know of at least one modern method of contraception and relatively few differences exist between rural and urban areas. One risk factor that cuts across all social classes is the lack of communication with parents and other responsible adults on matters of sexuality and reproductive health.

II.B.4. *Participation*

Another risk factor for Paraguayan youth are the low levels of participation in social organizations. According to the 2000/01 household survey, just 10 percent of youth ages 15-29 belong to a community group or organization, including churches.[15] This lack of connectedness raises the risk of unhealthy behaviors while presenting a challenge for programs that seek to work through networks of young people or through organized youth groups outside of the schools.

II.B.5. *Poverty and Economic Opportunity*

Poverty has a young face in Paraguay and is a major risk factor for young people. Poverty is widespread and increasing because of the decade-long economic contraction and the most unequal distribution of income in all of Latin America.[16] Moreover, poverty is concentrated among the young, with children and youth aged 5-24 making up three-fourths of the poor population and almost half of those living in extreme poverty. A quarter of the 15-24 year old population is unemployed, and the rate is higher for young women than for young men. In rural areas, close to 38 percent of 15-24 year olds is poor

[14] Central Intelligence Agency (CIA). 2003. *World Fact Book.* http://www.cia.gov/cia/publications/factbook/

[15] Dirección General de Estadística, Encuestas y Censos (DGEEC). 2003. *Juventud en Cifras. Difusión de Información Cuantitativa sobre la Juventud.* Asunción: DGEEC.

[16] Programa de las Naciones Unidas para el Desarrollo (PNUD), Instituto Desarrollo de Capacitación y Estudios, and Dirección General de Estadística, Encuestas y Censos (DGEEC). 2003. *Informe Nacional sobre Desarrollo Humano Paraguay 2003.* Asunción: PNUD.

and 23.4 percent is extremely poor.[17] The high rates of poverty and its concentration among the young are a major source of risk for unhealthy YRH behaviors. Limited economic and educational opportunities increase the risk of early and unprotected sexual activity, as well as encouraging sex work and related risky behaviors such as drug and substance abuse. At the same time, poverty is a consequence of risky sexual behaviors by perpetuating poor health and lack of educational opportunities; for example, many adolescent girls get pregnant and drop out of school. These behaviors also have negative intergenerational effects on the health, education, and job opportunities for the offspring of poor youth.

II.C. Policy Environment for Youth Reproductive Health

In addition to the social, cultural, and economic context discussed above, young people's reproductive health behavior also takes place within a political context. Worldwide experience has shown that a supportive policy environment can be an important factor in improving YRH outcomes. Official written laws, policies, plans, and strategies provide important political and budgetary support to national efforts to increase access to YRH care. Supportive statements and attitudes of public officials are also important to mobilize popular and political support and to energize civil servants and citizens. While the existence of policies is an important step, implementation of policies and plans is also key and is affected by the existence of effective and coordinated institutions and programs, advocacy, involvement of stakeholders, and political and budgetary support. These together make up the policy environment. In Paraguay, both supportive and non-supportive elements exist in the policy environment, summarized below.

II.C.1 *Supportive Elements in the Policy Environment*

Laws, policies, and plans that explicitly support YRH. Paraguay enjoys a robust array of laws and policies that support YRH efforts. The most important of these, summarized in Table 6, include the following:

- *National Adolescent Health Plan (Plan Nacional de Salud Integral de la Adolescencia, 2002-2006).* The Ministry of Health developed this plan with the support of the United Nations Population Fund (UNFPA) and the Pan American Health Organization (PAHO) and provides an important underpinning to the Ministry's work on adolescent health. The goal of the plan is to promote healthy environments, habits, and behaviors among adolescents and to prevent risk factors. Two of the plan's four indicators of success relate directly to improvements in reproductive health and include reducing early unplanned

[17] Secretaría De Acción Social, Presidencia De La República. 2002. *Estrategia Nacional De Reducción De La Pobreza Y La Desigualdad*; World Bank. 2004. *Paraguay: Social Development Issues for Poverty Alleviation* Country Social Analysis.

pregnancies by 25 percent and reducing STIs/HIV by 25 percent between 2003 and 2006.[18]

- *Code for Children and Adolescents (Código de la Niñez y Adolescencia).* Approved in mid-2001, the law provides important political support to the National Adolescent Health Plan and other activities that promote adolescent reproductive health. With respect to sexual and reproductive health, its most important provisions lie in article 14, which "guarantees integrated sexual health services and education to children and adolescents, who have the right to be informed and educated according to their stage of development, their culture, and their family values." The law further states that adolescent sexual and reproductive health programs should uphold standards of confidentiality and free choice while respecting the rights and obligations of parents and teachers.[19]

- *National Sexual and Reproductive Health Plan (Plan Nacional de Salud Sexual y Reproductiva, 2003-2008)*. Developed by the intersectoral National Reproductive Health Council, this plan delineates two areas of action specific to adolescents: education on sexual and reproductive health and services designed specifically to meet the sexual and reproductive health needs of adolescents. The plan also includes adolescent-specific success indicators in the areas of training and information.[20] USAID, UNFPA, and other donors are currently supporting the development of departmental action plans.

- *Poverty Reduction Strategy (Estrategia Nacional de Reducción de la Pobreza y la Desigualdad).* This 2002 document is an important national statement of priorities for reducing poverty. Its broad lines of action aim to provide the basis for action on the part of the government and to guide support from international donors, in particular the World Bank and other international financial institutions. The strategy emphasizes in many ways the importance of youth investments to achieving poverty reduction and sustained economic growth. Moreover, as a specific part of the suite of priority strategies proposed to generate income and build human capital, the strategy includes differentiated health services to adolescents and young people in extreme poverty.[21]

- *Other relevant policies* that support YRH activities include the National HIV Strategic Plan 2001- 2004 and the 1999 AIDS Law. Paraguay is also a signatory to, and its Congress has approved a number of international agreements, that support adolescent and youth reproductive health and rights including the

[18] Ministerio de Salud Pública y Bienestar Social. 2002. *Plan Nacional de Salud Integral de la Adolescencia, 2002-2006.* Asunción: Ministerio de Salud.
[19] Barboza, Lourdes and Teresa Martinez. 2001. *Compendio ... niñez. Marco normativo de los derechos de la ninez y la adolescencia en el Paraguay. Tomo II. Instrumentos Jurídicos Nacionales.* Asunción: AMAR (Proyecto de Asistencia Integral a Menores en Situación de Alto Riesgo).
[20] Ministerio de Salud Pública y Bienestar Social. 2003. *Plan Nacional de Salud Sexual y Reproductiva, 2003-2008*. Asunción: Ministerio de Salud.
[21] Secretaría de Acción Social, Presidencia De La República. 2002. *Estrategia Nacional De Reducción De La Pobreza Y La Desigualdad.*

Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Labour Organization Convention on Eliminating the Worst Forms of Child Labour, and the Optional Protocol to the Convention on the Rights of the Child on Child Soldiers. Paraguay is also a signatory to the 1989 Convention on the Rights of the Child, the 1994 Cairo Program of Action, the 1995 Beijing Women's Conference Plan of Action, and the UN General Assembly's 2001 Special Session on HIV/AIDS. Observers expect the comprehensive youth law, scheduled for passage in 2005, to strongly support effective YRH activities.

Table 6. Key Policies Addressing Youth Reproductive Health in Paraguay

Policy	Agency/Sector	YRH Focus Areas
National Adolescent Health Plan *(Plan Nacional de Salud Integral de la Adolescencia, 2002-2006)*	MOH	Teen pregnancy prevention Reduction in HIV/STIs
Code for Children and Adolescents *(Código de la Niñez y la Adolescencia 2001)*	Multisectoral	Right to health care; Right to sexual and reproductive health services and information
National Sexual and Reproductive Health Plan (*Plan Nacional de Salud Sexual y Reproductiva, 2003-2008*)	MOH	Identifies YRH as a priority; Explicitly supports education and information
Poverty Reduction Strategy 2002 (Estrategia Nacional de Reducción de la Pobreza y la Desigualdad)	Multisectoral	Includes a focus on youth; Specifies adolescent health as a priority action
National Youth Law and Strategic Plan (expected passage in 2005)	Multisectoral	Broad youth policy; Expected to support YRH issues

Institutions for policymaking, coordination, and implementation. Paraguay has established several important institutions that favor the development and implementation of supportive YRH policies (see Table 7 below). These include the National Adolescent Health Program (*Programa Nacional de Salud Integral de la Adolescencia*) within the Ministry of Health; the Vice-Ministry of Youth (*Viceministerio de la Juventud*), housed within the Ministry of Education and Culture; the National Secretaríat for Children and Adolescents (*Secretaría Nacional de la Infancia y la Adolescencia-SNIA*) created in 2001 with ministerial rank; and the intersectoral National Reproductive Health Council (*Consejo Nacional de Salud Reproductiva)*. Coordinating bodies also exist at the departmental and municipal levels, and include Departmental and Municipal Children,

Adolescent, and Youth Councils (*Consejos de la Niñez y la Adolescencia; Consejos de Juventud*). (See Appendix 2 for details on most of these organizations.)

Active civil society. Civil society in Paraguay contains a fair number of advocacy and policy groups that work on YRH or YRH-related issues. These include BECA, CDIA, *Grupo de Acción Gay-Lésbico Transgénero*, *Luna Nueva*, *Fundación Vencer*, and the National Society of Adolescent and Child Gynecology and Obstetrics (see Appendix 2 for details on these groups). The last ten years has also seen rapid growth in the number of youth groups, with more than 70 groups nationwide dedicated to youth issues, most church-affiliated.[22]

Table 7. Main Coordination, Policymaking, and Advocacy Groups Working on Youth Reproductive Health Issues in Paraguay

Program (organization)	Activities	Funding/Notes
Coordinator for the Rights of the Child and Adolescent (Coordinadora por los Derechos de la Infancia y la Adolescencia—CDIA)	Policy development, implementation, coordination	
National Reproductive Health Council (*Consejo Nacional de Salud Sexual y Reproductiva*)	Policy development, implementation, coordination	USAID, UNFPA, UNICEF
National Youth Network (*Red Nacional de la Juventud*)	Coordination among youth NGOs	
Vice Ministry for Youth (*Viceministerio de la Juventud)*	Policymaking, coordination, advocacy within government	Government budget, GTZ, UNFPA
National Adolescent Health Program (*Programa Nacional de Salud Integral de la Adolescencia)*	Policymaking, coordination of MOH adolescent health services	Government budget, GTZ, UNFPA, PAHO
Secretaríat for Children and Adolescents (Secretaría Nacional de la Infancia y la Adolescencia-*SNIA*)		Government budget
Fundación Vencer	Advocacy for PLWHA, policy development, access to antiretrovirals	
Gay-Lesbian Group (*Grupo Gay-Lésbico)*	Advocacy for gay rights, HIV prevention, stigma reduction	

[22] World Bank. 2004. *Paraguay: Social Development Issues for Poverty Alleviation* Country Social Analysis.

Few policy restrictions. Few, if any, laws exist that impede the provision of reproductive health care to adolescents. Age barriers for contraceptive use and HIV testing are nonexistent. Sexually active adolescents are considered to be "emancipated minors" and thus exempt from laws or policies requiring health workers to obtain parental consent before providing contraception, HIV testing, or other reproductive health care. The major medical associations are also generally supportive of adolescent reproductive health efforts. Leading NGOs working in reproductive health such as PROMESA and CEPEP also have supportive policies for young people and have taken steps to involve young people more effectively in policymaking and programming. Laws and policies are generally supportive of reproductive health efforts overall and the Ministry of Health has specifically authorized widespread sale and distribution of all contraceptive methods, including emergency contraceptive pills. Furthermore, the MOH has approved and published norms for post-abortion care including use of manual vacuum aspiration for treatment of incomplete abortion.[23]

A flourishing private commercial sector. The health sector in Paraguay offers a wide range of private commercial outlets including clinics and hospitals, doctors in private practice, and pharmacies. Moreover, contraceptives are widely available in commercial outlets such gas stations and supermarkets. These outlets provide a range of choices for adolescents and youth with the money to seek products and services and who often prefer private commercial settings to the public sector.

II.C.2. *Non-supportive Elements in the Policy Environment*

Alongside the supportive elements discussed above exist several important factors that impede effective formulation and implementation of YRH policies and programs. Most of the weakness in the policy arena is a result of poor implementation of existing policies and plans.

Poor coordination among stakeholders. The lack of an effective national coordinating body on YRH has hampered implementation of activities contemplated under the various plans discussed above. The National Technical Group on Adolescents contemplated in the adolescent health plan has not yet been formed or become effective. Likewise, attempts to create a working group on adolescents within the National Reproductive Health Council have been unfruitful to date. At the level of institutions, coordination and collaboration on YRH has been sporadic at best and is often beset by institutional jealousies and clashing interests. Relations between the public sector and NGOs are still developing. Although development of the National Sexual and Reproductive Health Plan was truly national and participatory, involving the full range of stakeholders and occurring in an orderly and transparent way, this was not the case for the design of the National Adolescent Health Plan. As a result, the plan is not recognized as national in

[23] Ministerio de Salud Pública y Bienestar Social and Ipas. 2003. *Guía de Procedimientos en Anticoncepción Post-Evento Obstétrico y Aspiración Manual Endouterina (AMEU)*. Asunción: Ministerio de Salud and Ipas.

scope and few groups outside of the central MOH know about it. Furthermore, no nationwide network exists of young people working on reproductive health issues.

Lack of participation by youth in policymaking. Young people had little input into the development of the most important policies and plans described above and are generally absent from current decision-making forums. For example, the participation of young people in the development of actions plans for sexual and reproductive health at the departmental level has been minimal.

Resource constraints. Low and tenuous funding has hampered implementation of YRH programs. Almost all existing programs - whether public or NGO - face moderate to severe funding constraints. Broader financing problems for the public sector as a whole are at the root of the problem, with additional problems specific to the functioning of adolescent health programs. By subsuming its adolescent program within the broader budget for reproductive health, the MOH has given the adolescent program very little control over funding levels. Support from international donors, even when relatively long-term, has only covered a set of activities limited in type and in geographic reach. With the recent ending of support from German Technical Cooperation (GTZ), MOH activities currently are particularly vulnerable. Although recent organizational changes have raised the chances that the adolescent health program will secure a separate line item budget, there is no guarantee that such a budget will be sufficient to have a major impact on adolescent health. Furthermore, although planned World Bank and Inter American Development Bank (IDB) loans in the health sector promise to strengthen overall health sector functioning and to focus on maternal and child health, in their current form they lack specific support to strengthening YRH care. Among NGO programs, virtually no YRH activities have secured a steady source of funding, one that goes beyond one or two years in duration.

Low priority given to youth concerns more generally. The lack of youth participation in and the resource constraints on YRH programs reflect the low priority the government and society as a whole gives to adolescent and youth issues. The reasons for this are varied but may partly stem from a weak tradition of youth participation in public life and national decision-making. This lack of priority affects health and a range of related youth activities such as sports, education, and cultural activities.[24]

Political and religious opposition to YRH efforts. Conservative and religious opposition to YRH efforts is relatively muted, but continues to be an important brake on policy implementation. Although openly pronatalist policies are generally a relic of Paraguay's past, the current President has made several recent high-profile public statements promoting larger families. The results of the 2004 ENDSSR survey, showing a significant fall in fertility rates, are likely to provide ammunition to conservative political elements who claim that Paraguay is an "empty" country that needs populating. This may diminish public support for family planning services including for young people. Opposition from conservative religious groups - both the Catholic Church and evangelical Protestant

[24] World Bank. 2004a. *Paraguay: Social Development Issues for Poverty Alleviation* Country Social Analysis.

churches - continues to pose potentially a greater threat to expansion and improvement of YRH care. Religious-based opposition, for example, blocked the start of the MOH's adolescent health program for almost two years in the late 1990s and prevented airing a mass media campaign to promote emergency contraception. Likewise, informants cite conservative elements within the Ministry of Education as an underlying reason for the slow implementation of the country's relatively good policies and programs on school-based sexuality education. Authors of the National Reproductive Health Plan also cite resistance from religious groups as one of the principal barriers impeding improvements in sexual and reproductive health.[25]

Few groups supporting YRH care want to risk open confrontation with religious authorities and thus opt for a "low-profile" strategy that aims to be inclusive of religious groups and to defuse potential controversy. Indeed, many Paraguayan NGOs work hand-in-hand with churches or church-sponsored groups to achieve mutually agreed-on goals of reducing risky youth behaviors such as teen pregnancy and early, unwanted sexual activity. A director of one the adolescent clinics noted the good relations the clinic has with the Church and that Catholic schools have requested staff to do sexuality education. Relations are, however, not always so cordial. In a recent example, a Church official sent a letter to public school officials "prohibiting" the entry of certain groups (including *Arte & Parte)* to do sexuality education. Although such open confrontation is lessening, there has been an alarming growth of conservative religious-sponsored efforts to spread misinformation about sexuality and reproductive health. One illustration is the distribution to schools of educational materials that give false and misleading information about condoms (see section on Sexuality Education below). While purportedly promoting religious values, such actions in effect undermine public health goals.

II. D. Existing Youth Reproductive Health Programs

The array of existing YRH programs in Paraguay is relatively limited and generally small in scope compared to many other countries. Programs exist in both the public and NGO sectors, and the private commercial sector remains a very important source of YRH care. Very few USAID-funded cooperating agencies operate in the country and international technical assistance is limited. The analysis in this section of existing programs is organized according to five main types or settings for programs and summarized in Table 8. Appendix 2 gives more detail on each of these YRH programs.

Table 8. Existing Youth Reproductive Health Programs in Paraguay

Program (location)	Activities	Funding
Health Facility-Clinical Services		
IPS-CASA (Asunción)	Adolescent clinic at IPS hospital	From general IPS budget; contraceptives from CEPEP
MOH-Adolescent Program (San Lorenzo, Capiatá, Coronel Oviedo, Limpio,	Adolescent health clinics	Formerly GTZ, now from general government budget, OPS, PLAN Paraguay

[25] Ministerio de Salud Pública y Bienestar Social. 2003. *Plan Nacional de Salud Sexual y Reproductiva, 2003-2008*. Asunción: Ministerio de Salud.

Ita, San Pedro)		
UNA-Centro Materno-Infantil (San Lorenzo)	Adolescent clinic	University budget
CEPEP-*Espacio Joven* (Asunción, Encarnación, Fernando de la Mora, San Lorenzo)	Adolescent clinics within CEPEP clinics	USAID, IPPF
Red Cross Hospital (Asunción)	Adolescent maternity ward within hospital	Red Cross, Spanish Red Cross, MOH
PROFAMILIA/CAIA-(Fernando de la Mora)	Adolescent clinic	Formerly UNFPA, now municipality, private funding
SAIA (Villarrica)	Adolescent clinic	Red Cross, MOH, Municipality, Catholic University
Community (youth development, peer education)		
CEPEP — Peer educators	Between 20-30 peer educators working out of the three adolescent clinics	USAID, IPPF
PROMESA — Arte & Parte	Peer educators working in Asunción and Central Department, in workshops and mass media programs	PSI Paraguay S.A. Swiss Embassy, others
Arte Joven Por la Vida	HIV prevention through the arts (theater, dance, art)	UNICEF
PLAN Paraguay	Community development, peer educators	
MOH — Adolescent Program	Peer educators attached to clinics	Formerly GTZ, now from general government budget, OPS, PLAN Paraguay
UNA-Centro Materno-Infantil	Peer educators attached to clinics	University budget
Red Cross-Shelter for Pregnant Adolescents	Teach parenting and livelihood skills, provide prenatal care	Paraguayan Red Cross
Fundación Marco Aguayo	HIV prevention	UNICEF and private donations
Mass Media		
PROMESA (Arte & Parte, Con "S" de Sexo)	Radio program Booklet with information about sexuality Interactive Web site with people's questions	95.5 FM Rock & Pop PSI Paraguay S.A. PSI Paraguay S.A.

Fundación Marco Aguayo	Web site with HIV/AIDS prevention focus for young people	UNICEF-funded
Commercial Retail and Social Marketing		
PROMESA/PSI	Sales of pills, condoms, and ECPs	PSI Washington USAID Other donors
Pharmacies	Contraceptive sales	Social marketing and commercial
Supermarkets and gas stations	Condom sales	Social marketing and commercial
Sexuality and reproductive health education (in-school and out-of-school)		
MEC	Classroom teaching of sexuality and reproductive health topics	Funded from general Education Ministry budget
BECA	Support to MEC in preservice curriculum design and teacher training	Funded by UNFPA
PROMESA (Arte & Parte and other projects)	Education for in-school and out-of-school youth	Swiss Embassy Canadian Embassy USAID
CEPEP-*Espacio Joven*	In-school workshops and presentations	USAID, IPPF

II.D.1. *Health Facility-Clinical Services*

Attracting youth to clinical services is a well-established challenge in many countries and Paraguay is no exception. Young Paraguayans are generally healthy and thus, relative to small children or adults, have less need to visit a clinic. Moreover, familiar barriers such as unfriendly health workers and inconvenient hours are a disincentive to many young persons seeking care in the clinic setting. Although Paraguayan youth have other options for access to reproductive health care — especially through pharmacies (see below) — their reluctance or inability to use health facilities leaves them at risk for greater exposure to STIs and to unintended pregnancy and its consequences.

Recognizing this problem, Paraguayan advocates for YRH care began in 1997 to establish models of adolescent clinical services that continue to function in varying degrees today. These services, that Paraguayans refer to as "servicios diferenciados de atención" (differentiated services)

Stand-alone MOH youth clinic in San Lorenzo

share some basic characteristics and goals. First, they aim to be interdisciplinary and employ specially-trained staff that combine provision of medical care with health education, counseling, and psychological services. In this way, they aim to tackle the interrelated needs of young people. Second, they aim to address the range of health issues that affect young people, including, but not restricted to, reproductive health.

Three types of adolescent clinical services are found in Paraguay. The first are stand-alone centers operating in a dedicated building. These include the Integrated Adolescent Services clinic (SAIA) in Villarrica, Center for Integrated Attention for Adolescents (Profamilia/CAIA) in Fernando de la Mora, and clinics run by the MOH in San Lorenzo (Hogar del Adolescente), Capiatá, and San Pedro. The second type are located within hospitals, clinics, or other facilities and include CEPEP's three "*Espacio Joven*" centers; Center for Support of Adolescent Health (CASA) run by the Social Security Institute (IPS) in Asunción; MOH clinics in the cities of Coronel Oviedo, Ita, and Limpio; and an adolescent maternity clinic operating within the main Red Cross hospital in Asunción. A third type service operates within an existing health facility, sharing space with other services but operating on a different schedule. The single example of this is located in the Maternal-Child Health Center in San Lorenzo.

A complete absence of rigorous evaluation limits judgments on the success or failure of these models. Nonetheless, an examination of service statistics shows mixed results in attracting clients. Some clinics are operating at or near capacity while many others are clearly underutilized. For example, while the SAIA clinic in Villarrica and the MOH clinics in Coronel Oviedo and San Lorenzo see about 15-20 adolescents per day, CEPEP's three clinics, the IPS clinic in Asunción, and the Profamilia clinic in Fernando de la Mora are seeing only about five clients a day. Moreover, the adolescent clinics overwhelmingly serve pregnant girls. Particularly in the public sector clinics, 80 to 90 percent of clients are seeking prenatal care. Health workers universally lament not reaching these young girls before they become pregnant and not preventing second and third pregnancies. In addition, with few exceptions, services do not adequately meet the needs of boys and young men. Not surprisingly, young men typically make up less than 10 percent of clients.

Youth center located within CEPEP clinic

A number of problems may limit access to and use of services. With the exception of the CEPEP and SAIA centers, clinics present a variety of barriers to contraceptive use.

Supplies and stock outs are a continual problem, reflecting larger problems within the public health system. In addition, in several of the clinics visited, including CASA-IPS, MOH clinics in San Lorenzo and Coronel Oviedo, and the Red Cross Hospital in Asunción, contraceptives are not available in the clinic itself. Rather, staff refer clients in need of contraception to specialized family planning clinics located in a nearby building or elsewhere within the same site. Health workers also display a range of misinformation about the use and action of different contraception, particularly hormonal methods and intrauterine devices (IUDs), unnecessarily restricting choices for young people. Other access problems include limited availability of STI diagnosis and treatment services, an almost universal lack of availability of on-site HIV testing for youth, and virtually no access to antiretroviral drugs for treatment of HIV/AIDS. In the public sector, clinics open in the mornings are inconvenient for adolescents, particularly for those who are in school or who work. Perhaps reflecting the low priority given to adolescents, one MOH hospital placed the adolescent health clinic in the hospital's basement next to the morgue. Many of the problems specific to the adolescent clinics reflect the broader crisis in public sector health services and systems.[26]

Although most of the clinics observed have stocks of brochures on contraception and other adolescent health concerns, other promotional efforts and outreach are very limited. Clinics do virtually no mass media promotion and most young people hear about the centers through word of mouth. With few exceptions, outreach efforts tied to the clinics are weak and underfunded, with outreach to rural areas particularly limited. Many of the clinics do outreach to schools but ties between schools and health services remain underdeveloped. Low levels of youth involvement in design, operation, and evaluation of clinical services is another factor that may limit demand for services.

An important strength of current adolescent clinic services is the relatively long and varied experience that includes models in both the public sector (MOH and IPS) and in important NGOs such as CEPEP and the Red Cross. This nourishes the growing recognition that the clinical health system must treat adolescents differently to succeed in attracting youth in sufficient numbers and in meeting their specific needs. The adolescent clinics are staffed by truly dedicated health workers, many of whom are working practically as volunteers because of uneven funding and lack of official support.

This core group of adolescent "champions" working within the health system is a potentially powerful source for change. One weakness, however, is their allegiance to a relatively rigid model of "differentiated" adolescent health clinical services that is of unproven effectiveness and appears to be relatively complex, costly, and difficult to sustain. Awareness of and openness to alternative approaches, including, for example, taking existing services for adults and improving their attractiveness or "friendliness" to young people, is lacking. Moreover, many clinics — even within institutions — appear to be working in isolation with little chance to exchange experience and ideas. The recent report on the *Tesaira* project of the MOH and attempts by CEPEP to begin disseminating

[26] World Bank. 2004a. *Paraguay: Social Development Issues for Poverty Alleviation* Country Social Analysis; World Bank. 2004b. *Project Information Document. Paraguay Health Project II.*

the relatively recent experience of its *Espacio Joven* project are steps in the right direction.

II.D.2. *Community Outreach*

Community programs take information and services to where youth live, work, and play. Through work with peers, families, and communities, they attempt to address many of the risk and protective factors that influence the reproductive health behavior of young people. Community programs also have the potential to reach underserved groups such as poor, rural, and out-of-school youth, as well as youth in high-risk groups such as street kids and sex workers. In Paraguay, the primary type of community program in the area of reproductive health has been peer education. A number of groups have been active in peer education efforts, with leaders including the local NGO Health Promotion and Improvement (*PROMESA*) through its *Arte & Parte* program and PLAN International. Almost all of the adolescent clinical services discussed in the section above have associated peer educators, known as "monitores." For example, CEPEP's *Espacio Joven* clinics each have 20-30 peer educators. The proven success of the *Arte & Parte* program, validated by a relatively rigorous evaluation that took place in 2000, along with peer education efforts sponsored under the MOH's *Tesaira* project, have bolstered the consensus in the YRH community that peer education is effective.

This Red Cross shelter for adolescent mothers is one of many community outreach programs targeting youth.

Still, many challenges remain. In addition to the inherent problems in maintaining an active, motivated nucleus of young volunteers, the lack of minimum basic standards in terms of length and content has led to serious deficiencies in the training of peer educators. Funding for peer education efforts has been sporadic and agencies tend to cut such activities first because they see them as an add-on to clinical services. Finally, although in theory peer education can reach rural areas, existing programs are still largely

UNICEF-PROMESA sponsored youth concert for World AIDS Day

urban. One exception is the small PLAN International program operating in eight rural communities.

Other forms of community outreach, including working with parents and workplace-based programs working through broad youth development programs to promote better reproductive health, have been relatively underutilized in Paraguay. The few experiences working with parents, for example, have been relatively unsuccessful. Lack of resources severely limits the scope of work clinic staff can do in outreach and education to surrounding communities.

II.D.3. *Commercial Retail and Product Social Marketing*

Contraceptives are widely available in pharmacies and other commercial retail outlets in Paraguay and are relatively affordable for young people given the competitive retail environment and the existence of social marketing brands through PSI/Paraguay. For the three leading contraceptive methods used by sexually active young people in Paraguay – condoms, pills, and injectables – pharmacies are the predominant source for obtaining each of them. Other retail outlets, such as gas stations and supermarkets, also typically carry condoms, as do most commercial venues where transactional sex occurs (e.g. motels).

Although young people predominantly use pharmacies and other retail outlets for their contraceptive purchases, there remain social and psychological barriers for many, especially embarrassment to ask clerks for contraceptives or fear of being seen by other clients who might gossip to friends or family members. Many young people that the assessment team spoke with mentioned these feelings of embarrassment or fear. When asked about ways to potentially minimize these kinds of social barriers, they responded positively to suggestions such as placing condoms on shelves instead of behind counters that are accessible only to store clerks, and installing condom vending machines – something that apparently has never been introduced in Paraguay. The same key youth informants did not feel that condom pricing was too high for the majority of young people.

The availability of low cost pills, condoms, and emergency contraceptive pills in pharmacies is a key result of the social marketing program of PSI/Paraguay. PSI/Paraguay is a local private for-profit enterprise that was formed by Population Services International (PSI) with PROMESA (an NGO formed as part of the latter's agreement with USAID/Paraguay that ended in 2001) to work in social marketing. PSI/Paraguay is an independent corporation affiliated with Population Services International.

The contraceptives marketed by PSI/Paraguay include two lines of condoms under the *Pantera* brand – a standard version retailing for G. 3,000 for a pack of three (about US$0.20 per condom at an exchange rate of 5,100 guaranies per U.S. dollar) and a "super-sensitive" version retailing for G. 4,000 per pack. The former are donated in part by USAID/Paraguay, and the latter are provided by PSI/Washington at a subsidized cost.

In addition to *Pantera*, PSI/Paraguay also markets an oral contraceptive under the brand name of *Segura* (retail price of G. 8,100) and an emergency contraceptive pill under the brand name of *Pronta* (retail price of G. 15,000). PSI/Paraguay used to market a female condom but discontinued the product due to lack of sales. Youth are one of the target groups for PSI/Paraguay's social marketing products.

According to PSI/Paraguay, *Segura* is the best selling brand of oral contraceptives on the retail market. Nevertheless, sales of *Segura* have plummeted this year from an average of 24,000 cycles/month to 8,000 cycles/month. The reason for this decline, according to PSI/Paraguay, is the widespread appearance in retail pharmacies of USAID-donated oral contraceptives to CEPEP and the Ministry of Health (which are not allowed to be sold in pharmacies), as well as the appearance of contraband oral contraceptives from Bolivia (USAID donations to PROSALUD).

Advertising for these socially-marketed products, as well as purely commercial brands, uses mass media as well as point-of-purchase promotional materials. Condoms in particular are widely advertised, on both television and radio. Pills are advertised primarily on radio and through billboards.

The assessment team had the opportunity to stop in various retail outlets in and around Asunción to inquire about the contraceptive brands available, note the existence and types of displays, and ask about sales trends. In an upscale pharmacy the team was told that *Jasmine* – an expensive oral contraceptive brand – was the leading seller, while *Sultan* and *Control* were the leading brands of condoms sold (the latter sold for G. 5,100 per three-pack). The pharmacy carried the PSI brands of *Segura* oral contraceptives and *Pantera* condoms, but did not have the emergency contraceptive pill (ECP) *Pronta*. However, it did carry two other brands of ECPs: *Inmediat* – a combined pill regimen from Argentina, and *Control* – a progestin-only ECP produced in Paraguay.

A visit to a middle-class pharmacy revealed that their leading brands of condoms sold were also *Sultan* and *Control*. Like the first pharmacy, they did not carry *Pronta* ECPs, but did carry *Inmediat* and *Control* ECPs. Their leading brand of oral contraceptive was *Microgynon*.

The assessment team also visited a Shell gas station and noted the display of *Control* condoms on the counter next to the clerk. These sold for G. 6,000 per three-pack. The PSI condom – *Pantera* – was not visible, but produced when asked. It sold for half the cost of *Control*. As in the pharmacies visited, *Pantera* was not the leading brand being sold in spite of its lower cost.

II.D.4. *Mass Media*

The power of mass media lies in its potential for reaching vast numbers of youth and raising their awareness and potentially influencing their attitudes and behaviors, though the evidence base is rather weak on the ability of mass media alone to affect behavior change. However, the ability of mass media to affect attitudes and social norms is well

documented and often a change in attitudes and norms is a necessary precursor to behavior change through other means.

As noted earlier, access to radio and television is quite high in Paraguay, with almost 90 percent of households surveyed in 2004 having both a radio and a television. Radio in particular is influential among rural and poor youth. By contrast, Internet access is quite low. Given the widespread access to television and radio, these forms of mass media have great potential for reaching large numbers of youth with messages about reproductive health. In fact, when the assessment team queried a select group of nine young people representing youth-serving organizations about the types of programs they felt could have the greatest impact on improving YRH in the country, the leading response was mass media programs targeting youth.[27] Other forms of mass media, including newspapers, magazines, billboards, and the Internet also have potential, though arguably less so that television and radio.

A weekly radio program, "Con S de Sexo," is run by youth and discusses reproductive health issues.

Various projects and organizations in Paraguay that work with youth have used or are using forms of mass media, either for advertising services or for promoting positive attitudes and behaviors. For example, the Center for Integrated Assistance to Adolescents – an MOH facility that the assessment team visited in Coronel Oviedo – uses radio to promote the services it offers to adolescents. The GTZ-supported *Tesaira* project used radio broadcasts and youth-oriented magazines to disseminate messages to youth about reproductive health. Currently a television program known as *Pelusa para vos* occasionally touches on reproductive health themes, as do programs presented on *Canal de la Familia* (the Family Channel).

One local NGO that uses mass media extensively to educate youth about reproductive health is PROMESA. Since 1997, PROMESA (through its *Arte & Parte* project) has undertaken many YRH communication activities through mass media, including:

[27] The youth representatives ranked four types of YRH programs in terms of their potential for having the greatest impact on the reproductive health of young people in the country if more funding were provided. Mass media programs ranked first, followed by school-based sex education and youth-friendly services (tied), followed by programs designed to increase condom accessibility.

- A booklet on teen sexuality entitled *Hablemos Claro Sobre Sexualidad* (Let's Talk Clearly About Sexuality)
- Weekly radio and television program *Con S de Sexo*
- Periodic participation as experts on TV and radio shows
- "Infosex" news flashes on adolescent reproductive health issues
- Newspaper columns

The target group for these activities has been adolescents from 15-19 years of age in Asunción and the greater metropolitan area.

The Focus on Young Adults Program evaluated *Arte & Parte* in 2000. The evaluation concluded, "Overall, the *Arte & Parte* project would have to be viewed as having been successful… The evidence suggests that the project increased the level of knowledge of selected sexual/reproductive issues…The project also appears to have increased the proportion of adolescents who subscribe to certain attitudes/beliefs…" Partly in response to evaluation recommendations, and partly as a response to cut costs after USAID support ended in 2001, *Arte & Parte* discontinued the television program and "Infosex" news flashes. The radio program continues, however, and *Arte & Parte* continues to distribute the booklet.

The assessment team had the opportunity to observe the one hour live radio program *Con S de Sexo* that airs Saturday mornings on "Radio Rock y Pop." The program centered around the theme of World AIDS Day and had three guests – representatives of UNAIDS, PRONASIDA, and *Fundación Vencer*. The format of the show included questions posed by the moderator as well as call-in questions/comments from listeners via telephone and instant messaging. The radio program airs at no cost to PROMESA and is heard throughout Asunción and adjacent departments.

II.D.5. *School-based Sexuality and Reproductive Health Education*

School-based education is a vital component of comprehensive reproductive health programs as it provides information and helps to form attitudes conducive to healthy sexual and reproductive behaviors later in life. Skills, such as how to resist pressure to have sex or how to correctly use a condom, are sometimes also taught in schools. Given that many parents are reluctant to discuss sexuality with their children, schools are often the only place where children and adolescents learn correct information and skills that can help them avoid sexually transmitted infections and unplanned pregnancies. For the information to be effective, however, it must be taught early enough and ideally reinforced by parents, peers, the media, and other influential sources. The downside of school-based education is that it often misses young people most at risk – out-of-school youth. This is a challenge that other types of programs that extend beyond the classroom must meet.

In Paraguay, sex education is taught in the public schools and is part of the official curriculum of the Ministry of Education and Culture (MEC). Beginning in fourth grade, students learn about human reproduction and the physiological changes involved in

puberty. The curriculum addresses AIDS and STIs beginning in fifth grade. Forms of STI and HIV prevention, including abstinence, faithfulness, and condom use, are part of the curriculum beginning in sixth grade. Contraceptive methods are included in the eighth grade curriculum and these subjects are reinforced at the high school level. While these subjects are part of the official curriculum, it is unclear to what degree they are uniformly taught in all schools.

Data from the 1998 ENSMI survey indicate that sex education is increasing by age cohorts, though still not universal by any means. The percentage of girls 15-19 who reported having received a class or talk on sex education in school was 67 percent, compared to 53 percent for women 20-24 years of age. Unsurprisingly, urban/rural differences in sex education are large, just as their differences in school attendance are large. The percentage of girls, 15-19, who reported having received a class or talk on sex education in school was 81 percent in urban areas and 48 percent in rural areas.

In 2002, MEC began to provide pre-service training to teachers in sexual and reproductive health and the prevention of child sexual abuse. With UNFPA financial support, MEC contracted a local NGO – *Base Educativa y Comunitaria de Apoyo* (BECA) – to provide the teacher training in the majority of the 22 teacher training institutes of the country. BECA produced two manuals for this training in 2003: the "Manual for the Prevention of Sexual Abuse in Children" and "Building Our Sexuality." The latter is a comprehensive manual on sex education that includes background information, learning objectives, participatory activities, and a self-administered test on each subject presented.

The assessment team reviewed the textbooks used in the classroom in grades four through nine and found them to be of variable quality in terms of content and presentation. The texts gradually introduce basic information on the sexual organs, changes that occur in puberty, reproduction, contraception, sexually transmitted infections, and HIV/AIDS, and build upon the information presented in the lower grades. Although the quality of the teacher's knowledge and presentation skills makes the greatest difference in classroom learning, some improvements in the textbooks could also help.

The assessment team reviewed supplementary pamphlets and videos that were donated to MEC and distributed to schools throughout the country (though no longer distributed, we were told). This material, called "Sex: The Lies and the Truth," was published by a local church-affiliated organization, *Obedira*, reportedly with financial support from Focus on the Family – a U.S. organization known for its support of abstinence-only sex education curricula. The *Obedira* pamphlet given to the assessment team, with the seal of MEC placed on it, makes the statement "condom promotion results in increased pregnancies among unmarried girls and increases the incidence of abortion." A very different statement about condoms is made in the teacher training manual produced by BECA and used by MEC. This manual emphasizes condoms in its presentation on STI and HIV/AIDS prevention, even making the claim that correct and consistent condom use is the "simplest and most effective" means of prevention.

In spite of a curriculum that is favorable to educating students about sexual and reproductive health, and in spite of textbooks that address these subjects, officials with whom we met in MEC lamented the lack of more instructional materials and the lack of in-service teacher training in sexual and reproductive health. They noted that while the UNFPA-supported program with BECA provides for pre-service training of teachers in sexual and reproductive health, no formal in-service teacher training exists and there is a need for materials to supplement the textbooks.

Perhaps as a response to the need for more teacher training and supplementary sexuality education classroom materials, the public schools have invited several NGOs to do workshops on sexual and reproductive health. PROMESA, in particular, has been very active in holding such workshops through its educational project, *Arte & Parte*. From January through November 2004, *Arte & Parte* carried out over 150 workshops in response to invitations it has received from public schools, primarily in greater Asunción. The topics of these workshops include contraception, HIV, STIs, negotiation, and partner communication. This educational outreach by *Arte & Parte* is funded by the Swiss Embassy. CEPEP is another NGO that frequently is invited to give talks on sexual and reproductive health in public schools. CEPEP also invites schools to visit its clinics and *Espacio Joven* program to make students knowledgeable and comfortable with the environs of the clinic and the youth program operating within it.

II.E. External Cooperation in Youth Reproductive Health

The number of international donors providing direct assistance to YRH efforts in Paraguay is relatively small (see Table 9). They include USAID, PAHO, UNFPA, and United Nations Children's Fund (UNICEF). USAID is currently a strong supporter of overall reproductive health efforts and has over the last five years supported a number of youth-specific programs including the *Arte & Parte* program and PSI/PROMESA's social marketing efforts. It currently supports CEPEP's *Espacio Joven* program and isolated activities under its locally-focused Health Alliance Project. The donor agency with the longest history of support and with the broadest program of YRH support is UNFPA. Both its previous and current five-year country assistance plans prioritize adolescent reproductive health. GTZ until very recently provided major funding to MOH's adolescent health program but took a strategic decision at the regional level to stop working on health programs per se and its country program now focuses on youth participation and broad youth development. The IDB and World Bank are major supporters of public sector health programs but lack a specific YRH focus in their loan activity. Both also support education reform and the World Bank recently supported a social analysis of Paraguay that included a focus on youth, but not reproductive health specifically. For more details on each of the major donors, see Appendix 2.

Table 9. Major Sources of External Donor Support for Youth Reproductive Health or Related Activities in Paraguay

Agency	Current Area of Support
Major Donors Providing Direct Support	
PAHO/WHO	Policy formulation
UNFPA	Policy; contraceptive donations including emergency contraception
UNICEF	Policy; HIV prevention through IEC
USAID	Contraceptive supplies; support for CEPEP's *Espacio Joven*; general health sector strengthening
Major Donors Providing Indirect Support	
GTZ	Until November 2004 was a major supporter of the National Adolescent Health programs
IDB	General Health Sector Strengthening
World Bank	General Health Sector Strengthening, Support for Maternal-Child Health Insurance scheme to reduce urban-rural and rich-poor disparities; Secondary Education Reform

III. RECOMMENDATIONS

Despite impressive gains in reproductive health indicators between 1998 and 2004, the assessment reveals important gaps in efforts to improve YRH in Paraguay and to help the country achieve its goals of poverty reduction and economic growth. The following recommendations address those areas where action is needed to help close the gap between youth reproductive health needs and current programs.

The first two sets of recommendations are aimed at USAID and include those the Mission is encouraged to act on in the short-term (now through the end of its current strategy – anticipated to end September 2006) and those the Mission could consider under its new strategy that is in the early stages of preparation. The assessment team formulated the recommendations for USAID/Paraguay using the following criteria:

- They are within the policy framework/objectives and comparative advantage of USAID
- They respond to the Mission's general policy directions (targeting the poor, rural focus, etc.)
- Within the Paraguayan context, they are feasible and responsive to local policies and structures
- They complement the activities of other donor agencies
- USAID can carry them out with its assistance mechanisms
- They minimize the management burden for the agency

Short-term recommendations fit the following criteria (in addition to those listed above):

- They are high priority, high impact activities that can cost-effectively strengthen current efforts
- They can begin quickly
- They complement and build upon existing activities and structures without creating large new projects
- They lay the groundwork for future large-scale activities
- USAID can carry them out quickly and minimize its management burden by adding to the scopes of work of existing partners with whom it has current bilateral agreements or contracts (CEPEP, Center for Development Information and Resources (CIRD), IntraHealth) or by using its partners with whom it has existing, or already planned field support mechanisms in place (YouthNet, CDC, DELIVER).

Long-term recommendations fit the following criteria:

- They are high priority, high impact activities
- They complement and build upon existing activities and structures
- They may involve more complex implementation mechanisms requiring higher levels of USAID management burden
- They imply greater coordination with local and international partners
- They may take longer to get started and to carry out

The third set of recommendations cover actions not meeting the criteria above for inclusion as a USAID recommendation, but that are still a high priority for consideration by government institutions, international and local NGOs, and the donor community.

III.A. USAID-specific Recommendations – Short-term

USAID is well-suited to help to immediately address gaps in ongoing programs given its historic role, understanding of the problem, and expertise in the subject matter, both within USAID/W and USAID/Paraguay, as well as through its cooperating agencies. USAID/Paraguay is encouraged to consider carrying out the following actions (summarized in Table 10 below) between now and the beginning of its new Country Strategic Plan (planned to begin October 2006).

ACCESS TO SERVICES

1. Improve the skills of existing providers of adolescent clinical services.

One of the ways USAID can move quickly to reduce some of the access barriers noted above is to sponsor training of existing providers of adolescent clinical services in the public sector and in NGOs. Such training could focus on improving needed skills, such as counseling adolescents in how to practice healthy reproductive health behaviors, including contraceptive options for sexually-active youth. Training should also include a

contraceptive technology element with a focus on youth, as medical barriers are present even in supposedly adolescent-friendly clinical services. For example, one health worker that the assessment team spoke with in an adolescent clinic expressed the view that injectables are inappropriate for women under 25 and that adolescents should only take special low-dose oral contraceptives since their bodies are "not ready" for standard-dose oral contraceptives provided by the MOH. When asked about counseling young people about emergency contraceptive pills, the health worker seemed very reticent and said she would only answer questions about ECPs if asked, but would not raise the subject with a young woman. These types of medical barriers and withholding of information are examples of what training in contraceptive technology and counseling would address. Depending on interest, such training could also focus on making existing health services for adults more appealing and accessible for youth.

Although some training in these subjects has been provided over the years to the MOH and other institutions through funding and technical assistance from outside groups such as PAHO, GTZ, and UNFPA, a need still exists for greater levels of training, particularly as new staff rotate through clinics and as technical knowledge increases. At the same time that such training would upgrade the knowledge and skills of health workers, it would also contribute to greater sharing of experiences in service provision and solidify a national network of individuals and groups working in this area. USAID could seek collaboration with local training organizations as well as with medical associations such as the National Association of Infant and Child Obstetrics and Gynecology, the MOH's National Adolescent Health Program, and the University of Asunción through its Maternal-Child Health Clinic.

Either a series of one-day technical meetings or a 2-3 day workshop should be offered to MOH and NGO health workers to train them in the areas described above. If necessary, self-instruction modules, such as FHI/YouthNet's Reproductive Health of Young Adults Module,[28] could be used for training, or combined with the technical meetings/workshop proposed.

ACCESS TO CONTRACEPTIVES

2. Minimize leakage of USAID donated contraceptives in commercial outlets.

According to PROMESA, there is widespread leakage of USAID-donated oral contraceptives to pharmacies in contravention of USAID policy. The source of the "contraband" oral contraceptives are (according to PROMESA) USAID/Paraguay donations to CEPEP and the Ministry of Health and USAID/Bolivia donations to PROSALUD. The donated oral contraceptives that end up in pharmacies are then sold at below-market values and undersell even the social marketing brand of *Segura* oral contraceptives. It is PROMESA's perception that this is a major reason for *Segura*'s declining sales this year. The assessment team did not have time to pursue this allegation in detail, nor explore the depth of the reported leakage. Nevertheless, this is a problem in many countries where donated commodities are sold to commercial outlets either by the

[28] www.fhi.org/en/Youth/YouthNet/rhtrainmat/Reprohealthyoungadults.htm

end-of-the-line providers, or by individuals along the distribution chain. The assessment team understands that USAID/Paraguay has already investigated this problem and taken steps to solve it. Because USAID/Paraguay already plans to request technical support from the DELIVER Project to help improve contraceptive supply, the team recommends that the Mission ask DELIVER to do a follow-up investigation to determine if the steps taken to date have adequately addressed the problem. USAID should also urge the Contraceptive Security Committee, recently formed under the National Sexual and Reproductive Health Plan, to periodically monitor the reported leakage problem.

3. Increase donation of condoms to PROMESA for youth activities.

Currently USAID/Paraguay donates *Pantera* condoms to PSI/Paraguay (complementing those that PSI/Washington provides at a subsidized cost). PROMESA distributes 30 percent of these donated condoms to high-risk vulnerable groups and NGOs. Proceeds from the sales of *Pantera* and PSI's other contraceptive products are used to procure replacement stock via PSI/Washington, as well as to fund PROMESA's educational activities.

Given PROMESA's focus on youth reproductive health through its *Arte & Parte* project and its demonstrated effectiveness in the past (according to the FOCUS evaluation of *Arte & Parte* in 2000), financial support of selected PROMESA activities is a sound investment for USAID to make on behalf of youth reproductive health. One way to provide immediate support on behalf of PROMESA's educational activities is for USAID/Paraguay to increase its current donations of condoms to PSI/Paraguay that would generate funds for these activities. PROMESA is capable of expanding and scaling up many of its youth-oriented activities with additional funding obtained from increased condom donations. These programs include sexual and reproductive health education to in-school and out-of-school youth, and a weekly radio program, among others.

4. Provide contraceptives for existing adolescent centers.

The team visited the PROFAMILIA Center for Integrated Attention for Adolescents (CAIA) in Fernando de la Mora. The center was previously funded by UNFPA and now operates with local resources, including personnel donated by the Ministry of Health. The center lacks contraceptives, yet serves approximately 700 adolescents per year, most of who come for gynecological or prenatal care, or for counseling following sexual abuse. The availability of contraceptives in a center such as CAIA could go a long way to meeting important pregnancy prevention needs. USAID should explore with UNFPA how to supply contraceptive methods to CAIA and any other known adolescent centers currently lacking contraceptives.

SEXUAL AND REPRODUCTIVE HEALTH EDUCATION

5. Support in-service teacher training in sexual and reproductive health and the development of complementary classroom materials.

The majority of girls in Paraguay complete elementary school and attend part of secondary school, thus making school-based sexual and reproductive health education a practical means for reaching most youth. Furthermore, a growing number of girls report having received a talk or class on sex education in school (2/3 in the 1998 ENSMI Survey). There is a great opportunity to make the most of this exposure to sex education topics by training teachers to effectively teach the subject and giving them additional didactic materials (videos, take-home pamphlets, posters, etc.) to complement the material presented in the natural sciences textbooks. Furthermore, the investment UNFPA and MEC are making in in-service teacher training will not be fully realized if follow-on in-service training is not done and if teachers are not provided with more than the current textbooks at their disposal. PRONASIDA and MEC have also agreed to begin teacher training in HIV/AIDS for grades 4-9, though have not secured funding to allow this to happen. Thus, there is a lot of interest among government authorities for teacher training to occur, but technical assistance and funding is lacking.

Although USAID does not have an education strategic objective in its portfolio, USAID should sign a Memorandum of Understanding (MOU) with MEC and identify and finance a local partner to undertake such teacher training and develop complementary sex education materials. Two local NGOs that USAID could consider are BECA (already providing in-service teacher training through a UNFPA-supported project) and PROMESA with *Arte & Parte* (already providing classroom instruction in response to invitations by individual schools) and other projects for out-of-school youth, including development of BCC tools.

An MOU with MEC and an agreement with a local partner to train teachers should be accompanied by an evaluation to document the results of the training. The evaluation should report on coverage indicators (number of teachers trained, number of schools with new sex education materials introduced, etc.) and changes in students' knowledge and attitudes with respect to reproductive health.

COMMUNICATIONS/MASS MEDIA

6. Support the design of a national communications strategy focused on youth sexual and reproductive health.

An important part of any overall attempt to improve youth reproductive health behaviors and outcomes is a communications strategy that provides the framework for carrying out individual communications activities, be they interpersonal, community, or mass media programs. The need for YRH communication activities can be justified at many levels, including the need to:

- promote existing services;
- educate young people about healthy behaviors and how to avoid risky behaviors;
- increase "enabling factors" to healthy behaviors, such as self-confidence in resisting pressure to have sex; and

- positively influence social norms surrounding youth reproductive health and contextual factors that influence reproductive health, including gender norms, age of marriage, female education, etc.

A national communications strategy is needed, and does not exist at present according to the informants contacted by the assessment team. An "IEC Strategy" was identified in the National Adolescent Health Plan and was supposed to be carried out from 2003-2006. According to the assessment team's key informants, this strategy was neither developed nor carried out.

Such a strategy would identify:

- target groups (e.g. out-of-school youth, parents, younger youth aged 10-14, etc.);
- key behaviors to focus on for each target group;
- key messages for each target group and behavior identified;
- communication channels to be used (television, radio, internet, school classrooms, etc.);
- materials needed (e.g. pamphlets, manuals, radio spots, etc.);
- roles of key participants in the strategy;
- monitoring and evaluation plan, including timeline, with responsibilities clearly articulated; and
- human and financial resources needed.

USAID should spearhead the development of a national communications strategy for youth reproductive health – perhaps as a stand-alone strategy or preferably as an element of an overall reproductive health strategy. USAID could involve its reproductive health partners in this activity, as well as other members of the existing National Reproductive Health Council and other donors working in youth reproductive health, particularly UNICEF and UNFPA. This recommendation is offered as a short-term recommendation with the understanding that implementation of the strategy would likely await USAID support under the new Country Strategic Plan.

POLICY ENVIRONMENT AND INTERAGENCY COORDINATION

7. Support the creation of a YRH committee within the National Reproductive Health Council.

The National Reproductive Health Council is a relatively well-functioning organization that is in the vanguard of pushing for concerted and national action on reproductive health issues. Although it is far from perfect, it is a recognized venue that encompasses both the public sector and NGO sector as well as the international cooperation community, of which USAID is an active member. Although it has functioning sub-committees on maternal mortality and on monitoring and evaluation, there has been difficulty in setting up a sub-committee on YRH. Such a move would strengthen action at the national level, improve coordination, and strengthen the inclusion of YRH activities at the local and regional levels, as contemplated in the departmental strategic plans now being completed with UNFPA support. Therefore, it is strongly recommended that

USAID help to strengthen the work of the council in this area by creating a committee dedicated to youth reproductive health.

8. Encourage the re-activation of the National Technical Group on Adolescence.

USAID can further act to improve interagency coordination and raise the quality of YRH services by encouraging the re-activation of the Technical Group on Adolescence contemplated in the current National Adolescent Health Plan. Although intended to be national in scope, intersectoral, and interdisciplinary, the technical group was active in the development of the current National Adolescent Health Plan but has since ceased to function. The technical group, operating under the auspices of the National Adolescent Health Program of the MOH, can encourage greater sharing of experiences among those working in adolescent health, and provide technical guidance and oversight to the MOH program and to other programs working in this area.

COMMUNITY/PARENTAL SUPPORT

9. Include YRH themes in the community work of the Health Alliance Project.

Community outreach and mobilization efforts are critical to the education of young people on sexuality and reproductive health, to support positive changes in social norms needed to support healthy reproductive health behaviors of young people, and to promote the use of clinical services and products and services available through retail outlets. One way for USAID to strengthen current community efforts is to include YRH issues more comprehensively in the community work USAID supports under the Health Alliance project that IntraHealth and CIRD carry out. Such work could prioritize strengthening community youth groups and reaching young people with information through peer education and other means. It could build on the projects already supported by USAID through CIRD that work on youth development at the local level. An example is support given to the Asociación Campesina de Desarrollo Integrado (ACADEI) to support 25 youth volunteers to work on policy issues in seven rural communities.[29]

PROGRAM DESIGN/EVALUATION/RESEARCH

10. Sponsor secondary analysis of the 2004 survey data.

Although survey analyses from the 2004 survey already include an excellent array of data on the 15-24 age group, additional targeted secondary analyses of the survey data not currently contemplated in the final report being prepared by CEPEP could enhance understanding of the reproductive health status and behaviors of young people. These include calculation of the median age at sexual debut, median age at marriage, source of contraceptives by age group, and health indicators for the 15-19 and 20-24 age groups broken out by socioeconomic quintiles. Such analyses would sharpen understanding of key risk and protective factors, provide further guidance on allocation of resources, and

[29] Areco, Jorgino. 2004. *Fortalecimiento de la Participación de Jóvenes Rurales en la Implementación de Propuesta Ciudadana.* BID Juventud.

inform advocacy on the importance of improving reproductive to reducing poverty and income disparities. USAID should ask CEPEP, under its current cooperative agreement, to carry out such additional analyses in early 2005, if necessary with support from CDC or other cooperating agencies.

11. Support a qualitative study of adolescents aged 10-19, with an emphasis on boys.

The lack of current programming for adolescent boys in part reflects a yawning gap in knowledge about their beliefs, knowledge, and practices in relation to reproductive health. USAID could make a major contribution to bridging this gap by supporting qualitative research for this age group. Such research would complement the information now coming out the 2004 ENDSSR survey and a 2001 study by CEPEP that examined male reproductive health but limited itself to young men 18-24 years of age.

12. Ensure that the planned BSS includes a youth focus.

Should the Mission go ahead with its intention to support a behavioral surveillance survey (BSS) that focuses on groups at high risk of HIV infection, it should ensure that the BSS adequately takes into account age factors recognizing that vulnerable groups (e.g. sex workers) are mainly young people under 25. The design and interpretation of the BSS should involve young people and groups working on YRH and HIV prevention among young people.

Table 10. Summary of Recommendations for USAID Short-term Support to Improving Youth Reproductive Health in Paraguay

Action	Gap Action Addresses	Illustrative Actors & Mechanisms	Donor Coordination	Time Frame
1. Enhance training of existing providers of adolescent clinical services.	Medical barriers; Deficiencies in counseling youth	YouthNet through field support; MOH, IPS, and local NGO clinics	UNFPA, PAHO	2005-2006
2. Minimize leakage of USAID donated contraceptives in commercial outlets.	Contraceptive stock-outs in MOH/NGO clinics and negative sales impact on CSM products	DELIVER through field support; Contraceptive Security Committee of the National RH Council	UNFPA	2005-2006
3. Increase donation of condoms to PSI/PROMESA for youth activities.	Lack of funding for youth activities	Central Contraceptive Procurement in USAID/W	n.a.	2005
4. Provide contraceptives for existing adolescent centers.	Quality, lack of method choice; Missed opportunities	Central Contraceptive Procurement in USAID/W	UNFPA	2005-2006
5. Support in-service teacher training in sexual and reproductive health and the development of complementary classroom materials.	Deficiencies in school-based sexuality education	MEC, local NGOs such as BECA or PROMESA	UNFPA	2005-2006
6. Support the design of a national communications strategy focused on youth sexual and reproductive health.	Lack of promotion of existing services; Unsupportive community norms; Lack of RH knowledge and positive attitudes	IntraHealth through its subcontract with possible TA from YouthNet and/or HCP (JHU/CCP) through field support; Local RH partners; National Reproductive Health Council	UNICEF, UNFPA, and other donors working in reproductive health	2005-2006

Action	Gap Action Addresses	Illustrative Actors & Mechanisms	Donor Coordination	Time Frame
7. Support the creation of a YRH committee within the National Reproductive Health Council.	Poor coordination	USAID directly	All donors on the Nat'l Reproductive Health Council	Early 2005
8. Encourage the re-activation of the National Technical Group on Adolescence.	Poor coordination	USAID directly	All donors on the Nat'l Reproductive Health Council	Early 2005
9. Include YRH themes in the community work of the Health Alliance Project.	Limited community outreach	IntraHealth through its subcontract and CIRD through its cooperative agreement	GTZ, UNFPA	2005-2006
10. Sponsor secondary analysis of the 2004 ENDSSR survey data.	Missing key YRH status information	CEPEP, under its current cooperative agreement with USAID	World Bank (quintile analysis)	Early 2005
11. Support a qualitative study of adolescents aged 10-19, with an emphasis on boys.	Lack of knowledge on boys	PROMESA, CEPEP, or other local group	UNFPA	2005
12. Ensure that the planned BSS includes a youth focus.	Lack of knowledge on youth and HIV	FHI	UNAIDS Theme Group	2005

III.B. USAID-specific Recommendations – New Strategy Period

This section presents USAID with two long-term options for addressing youth reproductive health needs under its new Country Strategic Plan. Because the new USAID strategy is still almost two years away and the level of potential resources is unknown, the long-term recommendations lack the specificity of those in the preceding section.

Approach #1—Stand-alone YRH program within the health strategic objective.

The first implementation option is to develop a stand-alone YRH project that would comprehensively address important gaps in the areas of service delivery, access to contraceptives, community outreach, sex education, and communications, while also working to facilitate a more favorable political and social context for YRH behaviors and programs. This approach has the advantage of being able to target attention and resources to help address the important reproductive health needs of Paraguayan youth. With a stand-alone YRH program, USAID/Paraguay and its implementing partners will be accountable to achieving results among this all-important segment of the population that is most in need of education and access to services. Addressing YRH needs in the context of a stand-alone program has the added likely benefit of being more attractive to funding sources. The likelihood of buy-in from other donors may increase in the context of a national YRH strategy. Many such donors may now be questioning the need for additional resources for the reproductive health needs of the general population in light of impressive gains in contraceptive use and lowered fertility documented in the recent national survey.

Disadvantages of a stand-alone program are the increased burden for USAID/Paraguay of managing such a program and potential resistance from current implementing partners and the Ministry of Health, who may not embrace the idea of redirecting their programs to better serve young people. Additional disadvantages may include limited financial sustainability (income generation from programs targeting youth is always extremely limited) and political resistance against providing contraceptive services to youth. To mitigate the management burden of such a program for USAID/Paraguay, several "management light" options are available, including providing field support to a USAID/W program that can be responsible for program implementation, or a task order with a previously-competed indefinite quantity contract (IQC) such as TASC II.

The following could be potential components of a long-term comprehensive USAID program to improve youth reproductive health:

ACCESS TO SERVICES/CONTRACEPTIVES

1. Improve the youth-friendliness of health services.

USAID could support mainstreaming youth-friendly services throughout the public sector (MOH) not only in the existing model of "differentiated" services. This would involve special training of health workers in counseling techniques, updates on contraceptive

technology and other health issues focused on the adolescent age group, and changes to clinic functioning to make them more attractive to young people.

2. Strengthen existing adolescent clinics.

At the same time, depending on which part of the country it focuses on, USAID could help to strengthen the existing adolescent clinics through improvements in human resources, hours, and availability of contraceptives and other supplies. USAID could support operations research to study the relative effectiveness and cost-effectiveness of the current adolescent clinic approach that is prevalent nationwide with a model that "mainstreams" youth-friendly services within existing services for adults.

3. Develop a youth-friendly social franchise.

Along the lines of "Green Star" in Pakistan, USAID could support the development of a national youth-friendly brand to include clinics in the public and private sector and non-clinical services such as pharmacies. Services would qualify for participating in the social franchise using an accreditation system similar to one developed for the South Africa Adolescent Health Initiative. A promotional campaign would help youth identify the youth-friendly outlets.[30]

4. Improve the youth friendliness of pharmacies.

For the three leading contraceptive methods used by sexually active young people in Paraguay – condoms, pills, and injectables – pharmacies are the predominant source for obtaining each of them. Nevertheless, anecdotal information suggests many young people are embarrassed to purchase contraceptives in pharmacies, both because of the reactions of pharmacy workers to a young person's request, as well as the fear of being seen by other shoppers. "Youth friendliness" in pharmacies would entail making products easier to purchase with a degree of confidentiality (e.g. placing condoms on store shelves instead of having to ask a pharmacy worker), training pharmacy workers to be non-judgmental and friendly to all clients (especially adolescents and young adults), and training pharmacy workers to answer common questions that young people may have, particularly about the use of pills, injectables, and emergency contraception. USAID/Paraguay could incorporate a "youth-friendly pharmacy" component to a stand-alone program, either as part of a youth-friendly social franchise initiative (recommended above), as an element in a commercial social marketing component, or as a discrete activity. USAID/Paraguay should also continue to support the availability of low-cost contraceptives in pharmacies, for example by continuing to donate *Pantera* condoms to PROMESA.

[30] For more information on social franchising, see the YouthNet publication, *LaVake, Steve. 2003. Applying Social Franchising Techniques to Youth Reproductive Health/HIV Services. Youth Issues Paper #2. Arlington, Virginia: YouthNet.* http://www.fhi.org/en/Youth/YouthNet/Publications/YouthIssuesPapers.htm

SEXUAL AND REPRODUCTIVE HEALTH EDUCATION

5. Support in-service teacher training in sexual and reproductive health and the development of complementary classroom materials.

Previously included as a short-term recommendation to USAID/Paraguay, this activity, if successful in the short-term, could be an element of a stand-alone program. In-service teacher training could be scaled up to reach the majority of elementary and secondary public schools (particularly teachers of grades four through nine) in selected departments. USAID could assist the MEC to do in-service teacher training at several levels, including the actual training of teachers through in-service workshops and the development and dissemination of complementary classroom materials.

This recommended focus on in-service teacher training is made with the assumption that UNFPA will continue to support pre-service teacher training in sexual and reproductive health. UNFPA currently channels support through BECA, which is training future teachers in the majority of the 22 teacher training institutes in the country. If UNFPA discontinues support of pre-service training, USAID could add this to the scope of a YRH stand-alone program.

6. Support MEC curriculum review and textbook development for sexual and reproductive health.

Sexual and reproductive health is part of the official curriculum of the MEC. Beginning in fourth grade, a separate health education curriculum begins which includes sex education. The content and presentation of the textbooks used in grades four through nine is of variable quality and could benefit from review and revision, assuring technical accuracy as well as presentation style that is readable and comprehensible. MEC welcomes external technical assistance to improve its classroom materials in this area, and USAID support for curriculum review and development of better textbooks would complement its support for teacher training recommended above.

POLICY ENVIRONMENT

7. Strengthen national networks and inter-institutional coordination.

A comprehensive approach to YRH under the Country Strategic Plan should also include a strong component that strengthens supportive elements within the policy environment. One action would be the creation of a national network of youth working on reproductive health issues. Such a network would help to coordinate efforts among the various groups and should include youth from the public and private sectors, including representatives from the Youth Secretariats (*Secretarías de Juventud*), now functioning at the departmental, and municipal levels. In addition to supporting the creation of a network specifically for young people, USAID can support strengthening of coordination among institutions working on youth reproductive health through sponsorship of national forums, newsletters, and other channels of communication and dissemination.

8. Support advocacy on the importance of YRH investment.

To strengthen commitment to YRH issues, and to youth in general, USAID should consider supporting advocacy activities that target politicians and Ministry of Finance officials who make final decisions on government resource allocations. Such advocacy could include cost and cost-benefit analysis that quantifies the impact of youth investments, including in teen pregnancy prevention and HIV/AIDS prevention, as, for example, has been carried with World Bank sponsorship in the Caribbean and other countries.[31]

PEER EDUCATION/PARENTAL SUPPORT

9. Strengthen and establish basic standards for formation of peer educators.

Peer education forms an important component of many existing programs but serious deficiencies exist in the training of peer educators. As part of its long-term approach to improving YRH, USAID should support the establishment of basic standards for training of peer educators that include content and number of hours, and that set performance and knowledge standards. Given the importance that many groups attach to peer education and its potential for reaching underserved groups, this support could contribute greatly to improved YRH outcomes.

10. Increase the involvement of parents.

In schools and communities, parents can play a greater role in YRH programming. Many young people look to their parents as a source of information on sexuality and contraception, but parents often feel unprepared to help. USAID support for innovative programs to involve parents could build on existing school and community organizations such as the parent-school associations.

COMMUNICATIONS

11. Support the implementation of a national communications strategy focusing on youth sexual and reproductive health.

A short-term recommendation to USAID/Paraguay was to support the design of a national communications strategy focused on YRH. Under a stand-alone project in the new strategy, the team recommends that USAID/Paraguay provide support for carrying out this communications strategy. A communications strategy will likely have many elements, and may include mass media advertising, education and/or "edutainment" (entertainment with a social message), community-based communication efforts (e.g. community fairs or concerts) or inter-personal communication through peer educators,

[31] Cunningham, W and M. Correia, 2002. *Caribbean youth development: Issues and policy directions.* Washington, DC: World Bank, Caribbean Country Management Unit, Poverty Reduction and Economic Management Unit, Latin America and the Caribbean Region.

teachers, or health workers. Accordingly, USAID and other potential supporters of the national communications strategy will be free to select which areas of the strategy they wish to support, making sure to coordinate such support to avoid duplication and assure support of all necessary components. Implementation of the plan should also be done in close coordination with the National Reproductive Health Council.

PROGRAM DESIGN/EVALUATION/RESEARCH

12. Include a male module in the next national demographic and health survey.

Presumably the Mission plans to support a nationwide demographic and health survey sometime during the course of its next Country Strategic Plan. If so, it should ensure that the survey includes a separate module looking at reproductive health knowledge and practices of young men aged 15-24, in addition to the module on young women. The information on young men would complement qualitative data from the focus group study recommended above and the data on young women.

Approach # 2—Mainstream youth in Mission strategic objectives.

A second long-term approach is to mainstream a focus on poor, underserved youth within each of the four strategic objectives that USAID is proposing under its new strategic plan: democracy, economic growth, health, and environment. For example, the democracy strategic objective could place particular emphasis on the participation of young people in the democratic process and in policymaking and implementation, perhaps with a specific health focus. This would complement current strategic directions of major donors such UNFPA, GTZ, and UNICEF. Within the economic growth strategic objectives, specific activities could target youth employment and livelihoods actions. The health strategic objective could support a scaled-back version of the activities proposed under Approach # 1 above. Within the environment strategic objective, the Mission could similarly support activities that have a youth focus aimed at educating and involving young people in environmental conservation and awareness as part of its focus on conservation and on two ecologically sensitive areas, the Dry Chaco and the Upper Atlantic Forests eco-regions.

A cross-cutting focus on poor and underserved youth would provide an overarching theme to the four strategic objectives and produce coherent local strategies and action plans. The national youth law and strategic plan expected for approval in 2005 will provide a solid policy framework for action. If the Mission wishes to retain a focus on improving YRH outcomes, this broad-based mainstreaming approach may also have greater impact because of its ability to act on some of the risk and protective factors that traditionally fall outside the purview of the health sector. On the downside, such an approach may dilute resource effectiveness by spreading USAID's support too thinly and limit activities to a particular region or subregion.

III.C. Additional Recommendations

These three additional recommendations cover activities outside the comparative advantage of USAID, but that the assessment team considers priorities for improving youth reproductive health in Paraguay.

ACCESS TO SERVICES

1. Create an academic specialization in adolescent health.

Currently no such specialization exists in any of the university faculties related to adolescent health — medicine, psychology, nursing, midwifery, and social work. Paraguayans interested in specializing must leave the country to do so. Creating a specialization would contribute to the long-term sustainability of adolescent health efforts and greatly lower the cost of training and in building up local expertise. Local health and educational officials, with the support of USAID and other donors, should strongly consider quickly establishing such specializations within existing training institutions in Paraguay.

ACCESS TO CONTRACEPTIVES AND OTHER REPRODUCTIVE HEALTH COMMODITIES

2. Provide antiretroviral drugs (ARVs) and contraceptives through the social security system.

Antiretroviral therapy is currently not available through IPS, though it has apparently agreed to begin providing ARVs to beneficiaries in need beginning in 2005. Contraceptives are likewise not currently available through IPS, though they were offered at times in the past. A stock of contraceptives obtained in 2004 from the Ministry of Health will shortly be exhausted and there are no plans to replace it. Given the very favorable cost/benefit ratio for contraceptive coverage for beneficiaries and their dependents (cost of service provision and procurement compared to cost savings from births averted), IPS should reinitiate the provision of contraceptive methods and make them available not only to covered workers, but most importantly, to their spouses and dependents who are likely the ones most in need.

Though the provision of ARVs and contraceptives through IPS is not a strategy that predominately focuses on youth, many youth in need of ARVs and contraception will nonetheless benefit, particularly if IPS broadens its coverage of these programs to include spouses and dependents of covered workers. IPS should be encouraged to fulfill its stated intention of providing ARVs to its beneficiaries (including spouses and dependents of covered workers) in 2005 and to begin purchasing and providing contraceptives as well.

3. Provide contraceptives for the Adolescent Center at the Red Cross Hospital, Reina Sofia.

The assessment team saw a very well-functioning adolescent center at the Red Cross hospital in Asunción – the only maternity hospital with a separate facility for adolescents. Gynecological, prenatal, and obstetrical care are all provided in a youth-friendly environment. However, the team was disconcerted to hear that the adolescent center does not provide contraceptive methods – only counseling and referral to a CEPEP consultation room for adults elsewhere in the hospital. One principle of quality services is to provide as many services as possible under one roof and not make clients return or go elsewhere for services that could be provided together. When asked why contraceptive methods were not offered in the adolescent center, the team was told that the Red Cross-CEPEP agreement stipulated that services be provided in this manner. This agreement should be modified so that CEPEP provides contraceptives directly to the adolescent center of the hospital rather than requiring adolescent clients to come to the CEPEP consultation area.

SCHOOL-BASED REPRODUCTIVE HEALTH AND SEXUALITY EDUCATION

4. Assure technically accurate information on reproductive health is presented in all teacher training materials, and in all textbooks and classroom resource materials used by teachers to instruct students in reproductive health topics.

In general, the teacher training manual on sex education produced by BECA and the textbooks used in grades four through nine are technically sound in their reproductive health content, though the textbooks could be improved in other ways in terms of their presentation style and by devoting more space to reproductive health topics. The one exception found by the assessment team was in a supplementary pamphlet donated to MEC by a local organization (*Obedira*) and distributed to schools throughout the country. The pamphlet, called "Sex: The Lies and the Truth," with the seal of MEC located on it, makes the statement "Condom promotion results in increased pregnancies among unmarried girls and increases the incidence of abortion." This type of disparaging and inaccurate information about condoms should be eliminated from any texts or supplementary materials used by MEC and any future offers of donated supplementary materials should be carefully reviewed for technical accuracy before being accepted and distributed to teachers.

While the MEC should be careful to avoid any inaccurate information about condoms in its teacher training or classroom materials, it should also give due consideration to abstinence and present it as the most effective method of pregnancy and HIV/STI prevention available to students. Unfortunately the BECA teacher training manual, *Construyendo Nuestra Sexualidad*, makes the claim that correct and condom use is the "simplest and most effective" means of HIV/STI prevention, listing it first among seven forms of prevention and listing abstinence fifth. Aside from this, the manual is an excellent resource for teachers with comprehensive information on contraception, STIs, physiology, sexuality, and domestic and sexual violence.

APPENDIX 1: ORGANIZATIONS VISITED AND INDIVIDUALS INTERVIEWED

Organization	Contact	Title
Government Agencies		
Ministry of Education and Culture (*Ministerio de Educación y Cultura*)	Nancy Benítez Teresita Aquino	Director of Curriculum Technical Coordinator in Health Education
National Program for AIDS Control (*PRONASIDA*)	Dr. Agueda Cabello	Program Director
Ministry of Health, Adolescent Health Program *(Ministerio de Salud Pública y Bienestar Social, Dirección de Programas de Salud Reproductiva del Adolescente*)	Ana Denis Lic. Norma Fornigli Dra. Mercedes Portillo Susana Quiñónez	Nurse, Technical Team Psychologist, Technical Team Health of Child Health Director, Adolescent Health Center, Capiatá
Vice Ministry for Youth (*Viceministerio de la Juventud*)	Arturo Giménez	Vice Minister for Youth
National University of Asunción, Maternal-Child Health Center *(Centro Materno Infantil, Facultad de Ciencias Médicas Universidad Nacional de Asunción*)	Prof. Dr. Vicente Bataglia Doldán	Head of Reproductive Health Dept.
International Agencies		
USAID	Wayne Nilsestuen Sergio Guzmán Graciela Avila Josceline Betancourt	Mission Director Deputy Mission Director Reproductive Health Officer Reproductive Health Advisor
UNICEF	Amado Lovera	Monitoring and Evaluation Officer and Focal Point for HIV/AIDS, Youth, and Emergencies
UNFPA	Dr. Roberto Kriskovich	Coordinator, Sexual and Reproductive Health Program
UNAIDS (*ONUSIDA*)	María Inés López	National Consultant
PAHO (*OPS*)	Dra. Carmen Rosa Serrano	Country Representative
International NGOs		
IntraHealth	Dr. Gregorio Soriano	Country Director
Local NGOs		
Base Educativa y Comunitaria de Apoyo - BECA	Margarita Rehnfeldt Celeste Houdin	Director Educator and Representative on the CDIA

Organization	Contact	Title
Coordinator for the Rights of the Child and Adolescent *(Coordinadora por los Derechos de la Infancia y la Adolescencia-CDIA)*		
Paraguayan Center for Population Studies (*CEPEP*)	Mercedes Melián Rafael Aquino Susana Halaburda	Head of Research Research Dept. Head of Communication and Resource Development
Foundation for Integrated Adolescent Health (*Fundación Salud Integral para la Adolescencia--FUNSIA*) Latin American Association for Child and Adolescent Gynecology (*Asociación Latinoamericana de Ginecología de la Infancia y Adolescencia - ALOGIA*)	Dr. Antonio Ruotti	Director of FUNSIA and President of ALOGIA
Fundacion Vencer		
PROMESA (*Promoción y Mejoramiento de la Salud*) PSI Paraguay	Sonia Marchewka Luz Figueredo Dominica Vera	Executive Director Marketing Director Project Coordinator
Health Clinics		
Social Security Institute, Center for Support of Adolescent Health (IPS-CASA)	Dra. Carolina Acosta Lic. María del Carmen Velazco	Coordinator Psychologist
Social Security Institute, Family Planning Clinic		Nurse
Red Cross Shelter for Pregnant Teens (*Hogar Maternal Andrés Gubetich – Cruz Roja*)	Dra. Dolores Castellano Dra. Lida de Bergues Lic. Verónica Arika	Director Volunteer Director Psychologist
Red Cross Adolescent Maternity Clinic (*Hospital Reina Sofía Cruz Roja Paraguaya Servicio a la Adolescencia*)	Dra. Dolores Castellano	Coordinator
CEPEP Family Planning Clinic, Red Cross Hospital	Cynthia Vera	Auxiliary Nurse
Espacio Joven - CEPEP Asunción	Mirta Ruiz de Díaz	Director of Health Programs
Espacio Joven – CEPEP San Lorenzo	Dra. Ana Avalos Dra. Gladis Larrieur	Clinic Director Gynecologist
National University of Asunción, Maternal-Child Health Center *(Departamento de Ginecología Infanto Juvenil*	Dra. Lizzie Galeano	Clinic Director

Organization	Contact	Title
Centro Materno Infantil)		
PROFAMILIA/CAIA - Center for Integrated Attention for Adolescents, Fernando de la Mora (*Centro de Atención Integral al Adolescente*)	Dr. Osvaldo Martínez Nuzzarello Dr. Marcos González	Director Coordinator
Ministry of Health, Adolescent Clinic, San Lorenzo (*Ministerio de Salud Pública y Bienestar Social, Hogar del Adolescente*)	Lic. Palmiro Saenger	Director
Integrated Adolescent Services – Villarrica (*Servicio de Atención Integral del Adolescente- SAIA*)	Dra. Ana Cristoff Besaleel Da Silva Dias	Director Coordinator
Ministry of Health, Center for Integrated Attention for Adolescents, Regional Hospital - CAIA, Coronel Oviedo	Dra. Alicia Osorio	Director

APPENDIX 2: ORGANIZATIONS INVOLVED IN YOUTH REPRODUCTIVE HEALTH

1. Government Agencies

Center for Integrated Assistance to Adolescents, Coronel Oviedo

The Center for Integrated Assistance to Adolescents (*Centro de Atención al Adolescente)* is a center operating within the Coronel Oviedo Ministry of Health hospital. It is a stand-alone center within the hospital with its own entrance and dedicated staff. The center began functioning four years ago by the initiative of the center's director and other hospital staff. Unlike other dedicated adolescent centers operating within the Ministry of Health, this center was not part of the GTZ *Tesaira* project, thus it has operated more independently within the Ministry and has had to work to secure many of its own resources.

The center is staffed by two obstetricians, an OB/GYN, a nurse auxiliary, and intermittent psychology students. The physician is present three days of the week. The majority of adolescent visits to the center are for pre-natal care. Births take place in the general maternity ward of the hospital. Prenatal visits are free of charge, while a fee is charged for births.

Promotion of the center's services is done by radio, as well as through the outreach efforts of the staff and its 32 adolescent promoters. The center sees about 15-20 adolescents per day (1,229 from January-October 2004). Besides prenatal care, the center provides general gynecological care, Pap smears, STI detection and treatment (using syndromic management approach), contraception, and psychological consultations.

Contraceptive methods are available at the center and usually in stock, according to the director. During one stock out, CEPEP provided the center with an emergency supply of methods. The assessment team witnessed the presence of Depo-Provera, Lo-Femenal oral pills, condoms (from India), and IUDs. The stock appeared to be a mixture of USAID and UNFPA-donated methods. IUD insertion is done at the center. Emergency contraceptive pills and STI drugs are available, including penicillin, metronidazole and oral antibiotics.

Although adolescents are seen in the center – separate from adult patients – they must line up in the morning with adult patients to get a number to be seen (a far from ideal situation). They then go to the center to await their turn. In the waiting room of the center, the assessment team saw family planning pamphlets from PROMESA and from the National Reproductive Health Program (produced by USAID and JHU).

The center's director noted that the principal needs of the center are: 1) a computer to complete reports and process data requested by the central level of the Ministry; 2) additional personnel, including a psychologist and social worker; and 3) educational

materials, including videos (they have a TV/VCR and previously had educational videos from PROMESA, but these were recently stolen).

Social Security Institute

The state-run Social Security Institute *(Instituto de Previsión Social – IPS)* provides health services to its members, about ten percent of the population.[32] IPS covers 9.3 percent of youth ages 15-29 (about 142,000 young people), but only 4.1 percent (about 18,000 youth) are classified as poor.[33] According to the ENSMI-98 (data is not available from 2004 survey), IPS provides just 1.1 percent of contraception to those women in fertile age using any method.

The national IPS hospital in Asunción established an adolescent health clinic in 1998, now known as the Center for Support of Adolescent Health (*Centro de Apoyo para la Salud del Adolescente* -- *CASA*). CASA, financed solely through the IPS budget, is located within the main hospital outpatient wing. According to the clinic director, it is the only adolescent clinic within the IPS system. The clinic director is an OB/GYN who completed a residency in adolescent health in Buenos Aires and is a member of the national society of adolescent and child gynecology and obstetrics.

Located on the first floor with easy access and down the hall from the family planning clinic, CASA serves adolescents 10-18 years of age Monday through Friday in the mornings. The clinic's staff consists of a ob-gyn, pediatrician, and two psychologists. Of the roughly five to seven adolescents per day on average they see (well below their capacity of about 20 per day), most come either for psychological problems or for gynecological and obstetric issues, including pregnancy and contraception. The clinic collects information using a special patient history form for adolescents and issues a separate youth identity card. Promotion of the services is minimal, and includes occasional outreach to schools. Because of its emphasis on obstetrics and gynecology, almost all of its clients are female. Often clients come accompanied either by they spouse, partner, or by their mother or other family member. Unless an adolescent girl belongs to IPS or is married to a member, she is not entitled to prenatal or birthing care under current IPS regulations.

Clinic staff counsel on the full range of contraceptive methods, but do not provide methods directly to adolescents. Youth wanting contraception are referred to a separate family planning clinic a short walk down the hall. That clinic is operated under an agreement with the MOH and staffed by a nurse who distributes methods and inserts IUDs. An adolescent in need of HIV-related services, including testing, is referred to the national AIDS program (PRONASIDA) for testing, counseling, services, etc. The clinic director has, to her knowledge, seen just one HIV-positive patient in her clinic.

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[32] World Bank. 2004. *Paraguay: Social Development Issues for Poverty Alleviation* Country Social Analysis.

[33] Dirección General de Estadística, Encuestas y Censos (DGEEC). 2003. *Juventud en Cifras. Difusión de Información Cuantitativa sobre la Juventud.* Asunción: DGEEC.

Ministry of Education and Culture (MEC)

The MEC imparts information in the classroom about sexuality, reproduction and sexually transmitted infections in a gradual manner beginning in elementary school and continuing through high school. In the first three grades of elementary school, students are taught about their bodies and the physiological differences between boys and girls as part of the natural sciences and health curriculum. Beginning in fourth grade, a separate health education curriculum begins in which sex education forms a part. Human reproduction is addressed beginning in fourth grade, as well as the physiological changes that occur in puberty, including menstruation. AIDS and other STIs are introduced beginning in the fifth grade text and reinforced in the sixth grade text, where forms of prevention are also introduced (abstinence, mutual fidelity, condom use, blood screening, and use of sterile syringes).

During the "third cycle" (grades seven through nine), the curriculum expands to address other themes related to sexual and reproductive health, including contraception, prostitution and abortion. In grades 10-12, students learn more in-depth information about reproduction, contraception, pregnancy, and childbirth.

Pre-service teacher training in sexual and reproductive health is provided in most of the 24 teacher training institutes in the country. MEC has an agreement with a local NGO to provide pre-service teacher training in this subject. The local NGO is *Base Educativa y Comunitaria de Apoyo* (BECA). A description of BECA's work is reported separately in this appendix.

Ministry of Health, Adolescent Health Program

The Ministry of Health (*Ministerio de Salud Pública y Bienestar Social)* is the major provider of health care in the country and second only to pharmacies as a source of family planning services, in 1998 supplying 27 percent of the family planning care in the country. The Ministry established an Adolescent Health Program (*Programa Nacional de Salud Integral de la Adolescencia)* in 1997 and crafted its first national adolescent health plan for the period 1997-2001. However, activities under the plan did not get underway until 1999 because of the then health minister's opposition to family planning. Until very recently, the adolescent unit operated as a sub-program under the Reproductive Health Department *(Dirección de Salud Reproductiva)*. In November 2004, the Ministry merged the program with child health to form a new Child and Adolescent Department (*Dirección de la Niñez y la Adolescencia*) reporting directly to the General Health Programs Directorate (*Dirección General de Programas de Salud*).

Under the previous organizational setup, government funding for the adolescent health program flowed through the Reproductive Health Department. GTZ through the Tesaira Project, UNFPA, and PAHO contributed significant funding and support for training of Ministry staff, equipping of clinics, and a variety of community outreach activities. GTZ ended its funding in November 2004 because of a shift to a strategy of broad support for

poverty reduction efforts. Currently, the program receives a small amount of external support from PAHO and from PLAN International for training and community outreach. Program officials are actively working to secure a separate line item within the Ministry's general budget for health programs to enhance sustainability and continuity.

At the central office in Asunción, a team of four people, including the director, Dr. Luis Armoa Garcia, a psychologist, nurse, and an OB/GYN, provide technical support and oversight to the program. The program currently operates under the 2002-2006 National Adolescent Health Plan. The plan sets four main objectives that include reduction of teen pregnancy and reduction of sexually transmitted infections, including HIV, in young people. The plan has four main results in the areas of policy, services, youth involvement, and IEC. Progress in carrying out the plan to date has been limited mainly to the area of services. The central technical unit directly supervises the operation of two adolescent health clinics, one in San Lorenzo and one in Capiatá. Both are stand-alone clinics operating a short distance from major regional hospitals, staffed by multidisciplinary teams of doctors, nurses, midwives, educators, and psychologists and serving adolescents 10-19 years old. The program indirectly supports another four adolescent health clinics, in the cities of Ita, Limpio, Villarrica, and San Pedro. Some of these operate within MOH facilities while others, such as SAIA in Villarrica (see description below), operate within NGO sites.

The vast majority of adolescents attending the MOH clinics are poor and are seeking prenatal care. In both the San Lorenzo and Capiatá clinics, 80 to 90 percent of clients are pregnant adolescents. The clinics serve very few young men, but do encourage men to attend educational talks with their pregnant partners. Although the clinics provide family planning counseling, the range of contraceptives on hand in the clinics is limited, stock outs of methods are common, and clients wanting pregnancy prevention services are referred to the family planning clinics located in the nearby hospital. In contrast to adult-oriented clinics in Ministry hospitals, which charge G. 5,500 (slightly less than one dollar U.S.) for a visit, the services at the adolescent clinics are free. Clinics are open from 7 a.m. to 1 p.m. and are operating at capacity, seeing between 15 and 20 adolescents per day. The San Lorenzo clinic served a total of 2,698 patients in 2003, more than double the 1,253 it served in 2001.[34] Clinics also do some patient education and have peer educators, known as "*monitores*," attached to each clinic that do some community outreach. Funds for peer educators and for staff to do promotion and to work outside the clinic are very restricted.

National Program for AIDS and STI Control (PRONASIDA)

PRONASIDA was established in 1990 as an entity within the Ministry of Health and Social Welfare responsible for coordinating the national response to AIDS, including HIV surveillance, prevention, testing and treatment, and establishment of norms. In 1998, responsibility for overseeing the national response to STIs other than AIDS was added to

[34] Ministerio de Salud Pública y Bienestar Social, Hospital Materno Infantil de San Lorenzo, Hogar del Adolescente. 2004. *Informe Anual de Actividades 2003*.

PRONASIDA's mandate. Since 1996, PRONASIDA has a separate budget provided by the National Treasury (US$661,052 in 2002).

PRONASIDA defines the HIV vulnerable groups to be men who have sex with men, female sex workers, youth, and injecting drug users (IDUs). The number of IDUs, however, is not very large in Paraguay.

PRONASIDA is beginning a new project with funding from PLAN International to train peer educators in the interior of the country to do HIV/AIDS education outreach. PRONASIDA also has reached an agreement with MEC to train teachers in HIV/AIDS (both pre-service and in-service training) in grades 4-9. Funding for this training has not yet been secured, however.

PRONASIDA has solicited funds on behalf of the government from the Global Fund to Fight AIDS, Tuberculosis, and Malaria in several grant rounds, but has been unsuccessful to date in receiving an HIV/AIDS grant (a grant focusing on tuberculosis was awarded). At least one of the applications has included youth as a priority target group for behavior change programs. According to the *Ultima Hora* newspaper, Global Fund approval has been held up do to a lack of government commitment and, in particular, due to a lack of coverage of antiretroviral therapy in the country's social security health system.[35]

According to PRONASIDA, one hospital in each health region offers HIV testing and providing counseling. However, many lack reagents so testing is not always available. Both ELISA and Rapid tests are available, the latter being provided with UNICEF funding. UNICEF funding is also allowing PRONASIDA to do more promotion of voluntary counseling and testing (VCT), including promotion to youth and pregnant women.

PRONASIDA is the only public source of antiretroviral medication in the country. It began purchasing brand-name ARVs in 1996 and added generics in 2000. As noted earlier, the social security system – the *Instituto de Previsión Social* (IPS) – does not procure ARVs, though it has promised to do so in 2005. According to a news report, Paraguay's social security system is the only one in Latin America that does not provide ARVs to its beneficiaries.[36] PRONASIDA currently provides ARVs to approximately 140 persons living with HIV/AIDS (PLWHAs) in need of therapy (out of approximately 400 who need therapy). Another 100 PLWHAs will soon begin treatment through a project financed in part by Brazil.[37]

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[35] Lima, P. (2004, May 27). VIH/SIDA: Salud presiona a IPS para que provea antirretrovirales. *Ultima Hora.* Cited in http://listas.rcp.net.pe/pipermail/sida-ets/2004-May/000677.html
[36] Ibid.
[37] Lima, P. (2004, Sept. 14). Exigen que IPS provea antirretrovirales a pacientes con VIH/Sida. *Ultima Hora.* Cited in http: //www.impactaperu.org/pages/noticias/noticias065.htm

Besides HIV/AIDS, PRONASIDA is responsible for overseeing the national response to sexually transmitted infections. Syphilis is at epidemic levels in Paraguay currently and, according to PRONASIDA, five percent of babies are born with congenital syphilis, the second highest rate in the region after Honduras. Syndromic management is used to detect syphilis and other STIs in many primary health establishments. In some maternity hospitals, a rapid test is being used – Rapid Plasma Reagin -- that does not need microscopic analysis, as does the traditional VDRL test. PRONASIDA reports only being able to supply penicillin for STI treatment, not other antibiotics nor metronidazole.

National University of Asunción, Maternal-Child Health Center

The medical school of the National University of Asunción and its associated teaching hospitals (*Universidad Nacional de Asunción, Hospital de Clínicas)* is the most important training ground for doctors in Paraguay. One the teaching hospitals, the Maternal-Child Health Center in San Lorenzo (*Centro Materno-Infantil*) encompasses a reproductive health department headed by Dr. Vincente Bataglia, former long-time chief of reproductive health services in the Ministry of Health. The center houses an adolescent clinic operating from 12 p.m. - 3 p.m, Mondays and Wednesdays. The government wholly funds the clinic through the university. The clinic shares the same space with other services, including the pediatric gynecology clinic, albeit with separate operating hours. Clients are charged G. 20,000 per visit, significantly higher than the 5,000 that is typically charged in MOH facilities. Between January and September of 2004, the clinic served 202 adolescents of a total of 17,000 patients in the center, or roughly three clients per day, well below its capacity.

Vice Ministry for Youth

The Vice Ministry for Youth (*Viceministerio de la Juventud)* is a unit within the Ministry of Education and Culture, with headquarters in Asunción. The government established the office in the early 1990s in response to the constitutional mandate establishing the need to incorporate youth into the country's development process. The Vice Ministry promotes policies in favor of Paraguayans ages 18 - 29. Much of its work is to advocate for youth issues within the government and persuade the various line ministries to give higher priority to youth issues in their planning and budgeting—a challenge given the traditional lack of attention to youth issues. An important recent step was the first-ever ministerial level discussion on youth issues held in 2003. As follow-up, all ministers now report yearly on their youth-focused activities.

With support from UNFPA, the Vice Ministry has begun a process of 15 regional and six national youth consultations that will culminate in the development of a national youth law that is expected to be adopted in 2005. The Vice Ministry sees this as an important step in articulating a coherent and coordinated policy on youth. Along with the proposed national youth law, which aims to provide broad guidelines for action and not be a comprehensive legal "code," the Vice Ministry plans to develop a strategic plan to implement the broad guidelines laid down in the law. The Vice Ministry is also receiving support from the IDB's youth program to support the policy development process.

The Vice Ministry also has a mandate to improve coordination on youth activities nationwide, in addition to strengthening existing networks of young people and youth-serving organizations. To strengthen ties between government and civil society it coordinates with the National Youth Network (*Red Nacional de Juventud*), a network of some 30 NGOs that include youth wings of political parties and university student associations. It also supports the establishment of Youth Secretariats (Secretarías de la Juventud) in the 17 departmental governments (*gobernaciones*). The Vice Ministry is very supportive of peer education, and, for example, has agreements with various NGOs, including with PROMESA (see below) to train peer educators. GTZ gave the Vice-Ministry technical support to work intensively in 4 departments in the interior of the country under the Good Government (*Buen Gobierno*) program.

2. International Agencies

German Technical Cooperation

German Technical Cooperation (GTZ) works in 131 countries worldwide. Until it ended its support in November 2004, GTZ through its *Tesaira* Project was a major funder of the MOH's adolescent health program. *Tesaira* covered a population of 350,000 adolescents in pilot regions that included poor areas of the Central and San Pedro Departments and of the capital, Asunción. Working at the national, regional, and local levels, the project trained 900 youth peer educators, helped to equip and train the staff of adolescent health clinics, and supported promotional and educational activities through community outreach, including radio broadcasts and youth magazines. The project was also involved in the annual school Olympics, and initiated the pilot projects Healthy Schools, and Healthy Towns and Cities. The project cooperated with Beiersdorf AG Paraguay, to develop a condom design that appeals to young people, combined with an appropriate marketing strategy.[38]

GTZ dropped its direct support for adolescent health activities after making a strategic decision at the regional level to discontinue work on health programs. Its country program now focuses broad support for good governance and poverty reduction efforts with an emphasis on youth participation and broad youth development that includes support for the Vice Ministry for Youth's Good Government (*Buen Gobierno*) program. GTZ cooperates with the KfW development bank in natural resource management, the Ludwigsburg Teachers' Training College in youth violence prevention measures, and three European companies within the scope of public-private partnerships for development.[39]

Pan American Health Organization (PAHO)

PAHO (*Organización Panamericana de la Salud-OPS)*, a regional arm of the World Health Organization, has assisted health efforts in Paraguay for 100 years. The local

[38] GTZ. 2003. *Annual Report 2002.*
[39] GTZ. 2004. *Annual Report 2003.*

office of PAHO has a mandate to strengthen the work of the Ministry of Health. Under its new director, who took the position three months ago, the office manages a wide range of activities on a relatively small yearly budget of $500,000. PAHO's emphasis is policy development, resource mobilization, and providing technical assistance drawing on its regional network of health experts. PAHO is a member of the National Reproductive Health Committee and also helped develop the National Adolescent Health Plan. It provided limited support to the Ministry's adolescent health services through training and technical assistance.

UNFPA

UNFPA has provided assistance to Paraguay since 1979. Past support helped the development and implementation of a model for comprehensive adolescent health care, including support for the CAIA clinic in Fernando de la Mora and SAIA in Villarrica (see below) and the development of an educational methodology for out-of-school rural youth. The goal of UNFPA's current $4.4 million 2002-2006 country program is to contribute to the government's efforts to improve the quality of life of the Paraguayan people and to reduce poverty through a more effective exercise of human rights, especially sexual and reproductive rights, as well as through the efficient incorporation and utilization of population and development tools in the country's development efforts. The country program has a strong focus on adolescents; one of its focus areas is reducing high adolescent fertility in rural areas. In the policy arena, the agency supported the development of the national sexual and reproductive health plan and is actively supporting the government in developing actions plans in each of the country's 18 departments. UNFPA's geographic focal areas are Caaguazú, Central, and Asunción, the most populous areas of the country. UNFPA also supports development of the Plan Nacional de Igualdad Hombre-Mujer. UNFPA's armed forces project was successful in incorporating reproductive health issues in 14 different military institutions and is now part of the regular program of the armed forces. Similar work with the national police was suspended. In sexuality education, UNFPA has been supporting the work of BECA (see below) to improve pre-service curricula and teaching training at 18 teaching institutions throughout the country. UNFPA also plans support for including reproductive health topics in adult basic education. UNFPA is a major supplier of contraceptives to Ministry of Health and coordinates closely with USAID on contraceptive supply issues. UNFPA is working with the IPS to strengthen its contraceptive supply system and to build its capacity to purchase its own contraceptives.

United Nations Children's Fund

United Nations Children's Fund (UNICEF) has worked in Paraguay since 1972 providing technical assistance, social mobilization, and advocacy for the rights of children and women. Much of UNICEF's activity is focused on the policy level, with a specific emphasis on implementing the new Code on Children and Adolescents, and in protection of children's rights. UNICEF has been very involved in the development and implementation of policies that focus on children and adolescents, including in the formation of the new Secretariat for Children and Adolescents (SNIA).

Within reproductive health, UNICEF's focus is on HIV/AIDS, now one of the agency's five priorities worldwide. In 2003, UNICEF supported the nationwide Young People for Life (*Arte Joven por la Vida*) program, mobilizing 20,000 young people between 12-21 years old through the arts and through peer education to address HIV/AIDS issue from a human rights standpoint. This program culminated in a high-visibility event in Asunción. Currently, UNICEF supports the youth-focused work of the AIDS Group *Fundación Marco Aguayo*, including a theater group that works in schools and community groups and a Web site, www.sabesloo.com.py, that focuses on HIV prevention within a youth development context. The agency continues to support the Young People for Life activities as well as other HIV-related youth events, such as a music concert to commemorate World AIDS Day. UNICEF's other work includes a planned $150,000 in funding for rapid HIV testing kits and facilitating the donation of ARVs from the Brazilian to the Paraguayan government. These efforts aim to strengthen prevention of mother-to-child transmission of HIV. UNICEF also supports PLAN International for training of adolescent peer educators in reproductive health/HIV prevention and mainstreaming of HIV/AIDS themes in the activities of the youth environmental group *Ecoclub*, reaching 9,000 youth with projects in nine cities.

3. International NGOs and Technical Assistance Organizations

IntraHealth International

IntraHealth is a U.S. cooperating agency working in Paraguay and is one of three partners of USAID/Paraguay that receives support through bilateral funding mechanisms (as opposed to Mission field support). IntraHealth began their in-country presence under the USAID PRIME II Project and have continued their work in maternal and reproductive health through a task order issued under the TASC 2 USAID/W contract.

IntraHealth's work in Paraguay is focused on improving the quality and accessibility of reproductive health care and strengthening maternal/neonatal health care services in selected areas of the country. Their activities do not explicitly target adolescents or young adults, though many youth benefit from their activities given the demographic profile of Paraguayan society and users of reproductive and maternal health services.

IntraHealth works with the Ministry of Health and other local partners in carrying out six primary programs in the area of reproductive health. These are: 1) establishing a referral/counter-referral system; 2) carrying out a behavior change communication (BCC) strategy; 3) strengthening the volunteer health promoter system; 4) implementing and disseminating the Reproductive Health National Plan and revising the reproductive health norms and protocols; 5) improving the quality of services using the Performance Improvement approach; and 6) establishing a supportive supervision methodology. These efforts are focused on the departments Central, Misiones, Cordillera, Itapua, and Asunción.

IntraHealth's work in the area of maternal health is concentrated in the department of Caaguazú and has four main components: 1) improving the quality of services at the

health facility level through the Performance Improvement approach; 2) strengthening the community response to obstetric emergencies through the Community Based Life Saving Skills methodology; 3) increasing community awareness and knowledge of emergency obstetric care and promoting exclusive breastfeeding through a behavior change communication strategy; and 4) strengthening the Ministry of Health's Maternal Mortality Surveillance system.

IntraHealth collaborates with various government and private organizations in the planning, implementation, and monitoring of the program. The organizations involved include the central and local levels of the MOH, local health councils, community partners, local NGOs, private-sector health workers, and medical societies such as the Paraguayan OB/GYN and nursing societies, as well as other stakeholders.

4. Local NGOs and Civil Society Organizations

Base Educativa y Comunitaria de Apoyo (BECA)

BECA is a local NGO affiliated with the International Catholic Children's Office (BICE). BECA was formed in 1991 and is dedicated to preventing physical and sexual abuse of children and adolescents, particularly among the poor. Over time, the organization incorporated the prevention of adult physical and sexual abuse and intra-family violence within its mission. BECA is a member of the coordinating group promoting the rights of children and adolescents known as CDIA (*Coordinadora por los Derechos de la Infancia y la Adolescencia — see below)*.

With financial support from BICE, BECA published a manual in 1998 on how to intervene in cases of sexual abuse among children and adolescents and included a list of institutions to contact in cases of sexual abuse. In 2003, BECA published a booklet on community intervention in cases of domestic violence and sexual abuse with financial support from the Canadian International Development Agency. The booklet includes specific information on who to contact if such abuse is detected in the community and offers advice to family and neighbors.

In 2002, BECA began working with the Ministry of Education and Culture to provide pre-service teacher training in sexual and reproductive health and the prevention of sexual abuse in children. With financial support from UNFPA, BECA has been training teachers in 18 of the country's 24 teacher training institutes, and has plans to work in the remaining six institutes. BECA produced two manuals for this training in 2003: the "Manual for the Prevention of Sexual Abuse in Children" and "Building Our Sexuality."

Coordinator for the Rights of the Child and Adolescent (CDIA)

CDIA is a consortium of 19 organizations dedicated to protecting the rights and promoting the welfare of children and adolescents. CDIA was formed in 1993. Among its principal objectives is monitoring the implementation of the Convention of the Rights of the Child, an international agreement signed by Paraguay in 1990 and legislated through

law (Law 57/90). CDIA helped to form the Secretariat for Children and Adolescents in the González Macchi administration.

CDIA has developed two plans with support from UNICEF: the National Action Plan for Children and Adolescents and the Plan Against Sexual Exploitation. Unfortunately, these plans have not progressed in their implementation due to a reported lack of government support.

CDIA receives financial and technical support from Save the Children Sweden, UNICEF Paraguay and PLAN International.

Paraguayan Center for Population Studies (CEPEP)

The *Centro Paraguayo de Estudios de Población* (CEPEP) was founded in 1966 and is the national affiliate of the International Planned Parenthood Federation (IPPF). CEPEP operates urban clinics in Asunción, Ciudad del Este, Encarnación, and San Lorenzo and supports seven other private clinics through its Associated Doctors (*Médicos Asociados)* program. According to the ENSMI-98, the NGO provides 3.6 percent of family planning services nationwide. CEPEP currently works under a cooperative agreement with USAID signed in 1999, also receives funding from the IPPF, and generates income through sales of products and services. Its clinics provide prenatal care, gynecological care, family planning and counseling, and pediatrics. In 2004, CEPEP "graduated" from USAID contraceptive donations and now purchases its own contraceptives through a revolving fund. CEPEP also provides contraceptives supplies to other organizations such as the Red Cross and carries out important research such as the series of reproductive health surveys that include the most recent 2004 national survey and a recent study on reproductive health needs of men.

CEPEP has always served the adolescent population but only recently established its first youth-specific program, known as Youth Space (*Espacio Joven*). With an initial financial support from IPPF, CEPEP began *Espacio Joven* in 2002 and now operates the program in three of its four clinics (Asunción, Encarnación, and San Lorenzo). Each clinic has set aside a separate space for clinical, counseling, and information specifically for young people.

The number of adolescent clients has increased in 2004 over 2003, but is still well under the program's capacity in both its medical and psychological/counseling activities. For the first half of 2004, the program's three sites, open from 8 a.m. – 5 p.m. on weekdays and 8 a.m. – 12 p.m. on Saturdays, provided clinical services to 1,020 young people ages 12-19, including 136 between 12 and 14 years old. Ninety percent of those served are girls and young women. During the same period, the clinics provided psychological services to 100 young people.[40] Each clinic has a network of 20-30 youth "monitors" who

[40] Centro Paraguayo de Estudios de Población (CEPEP). 2004. *Acceso de jóvenes a los servicios en las clínicas del CEPEP de Asunción, San Lorenzo y Encarnación, periodo Enero a Junio 2004*; Centro Paraguayo de Estudios de Población (CEPEP). 2004. *Cantidad de atenciones realizadas a adolescentes y jóvenes durante el periodo Enero a Junio 2004 en las clínicas de Asunción, San Lorenzo y Encarnación*.

do promotion and peer education. The adolescent clinic staff also does outreach with nearby schools and other community groups to promote its services and to provide sexuality education and information. Organizational policy mandates that two of CEPEP's seven board members be young people under age 25.

Paraguayan Red Cross (PRC)

The PRC is a large health provider in the country and has many youth activities. Principal among its health services is a maternal-child hospital in Asunción, one of the largest in the country. From 4,000-5,000 births take place annually in the hospital, one-quarter of which are to teenage mothers. The hospital has a separate adolescent center that offers gynecological exams, pre-natal care and obstetrical care. This is reportedly the only maternity hospital with separate physical space for attending adolescent patients.

Approximately 20-25 adolescents are seen as outpatients each day in the adolescent center. Besides receiving medical care, the adolescents also receive educational talks and counseling about various health topics such as family planning. Contraceptive methods, however, are not distributed in the adolescent center of the hospital. Instead, the adolescents must go to a separate family planning room operated by CEPEP in another location of the hospital. This is currently a source of disagreement between the adolescent center staff (who want the family methods in the adolescent center) and CEPEP (who wants to keep the methods under its control).

Besides operating the maternity hospital, the PRC also has a shelter for pregnant teens located near the hospital. Pregnant girls who are single and delivering their first child are eligible to enter the shelter beginning at the seventh month of pregnancy and remaining through 60 days postpartum. The girls come from all over Paraguay, referred by judicial authorities and police. Often these girls have been sexually abused by someone in their household. Younger girls, 11-15, make up the majority of the shelter's residents. The shelter can house up to 22 girls.

During their stay in the shelter, the girls learn many skills, including cooking and sewing, and they also receive counseling. The shelter does not facilitate adoptions and the girls are encouraged to keep their babies in spite of the circumstances by which they became pregnant. The shelter was remodeled with support from the Spanish Red Cross and operating expenses are covered through the sale of used clothes sold on consignment, and from the sale of empanadas.

The PRC has approximately 500 youth volunteers nationwide, with 100 in Asunción. These youth volunteers participate in the various activities of the PRC, including HIV/AIDS educational activities. They give talks on HIV/AIDS in schools and put on special events, such as for World AIDS Day.

PROFAMILIA/Center for Integrated Attention for Adolescents (CAIA), Fernando de la Mora

PROFAMILIA is a local NGO that developed the Center for Integrated Attention for Adolescents in the city of Fernando de la Mora in 1998. CAIA operated with funding from UNFPA from 1998-2001, with a budget of about $35,000 per year. UNFPA funded CAIA in Fernando de la Mora, and a similar center in Villarrica. Besides providing direct financial support, UNFPA also equipped the center, which had been provided for free by the Municipality of Fernando de la Mora.

CAIA functioned at full capacity through the length of the project, but had to scale back its services significantly when UNFPA funding ended in 2001. The project funded medical and psychological consultations and educational programs. CAIA also recruited 400 adolescent volunteers to act as peer educators and distributors of contraceptive methods to their sexually active peers.

Since 2002, CAIA continues to offer services, but scaled back from the level they had provided previously. For example, they have a physician on site two days a week in the morning, and a psychologist three days a week, provided by the Ministry of Health. Supplies of medicines and contraceptives are very irregular and CAIA refers adolescents who need contraception to the MOH health center in town. The health center also refers adolescents to CAIA for services that they are better prepared to provide. The police and judicial authorities in Fernando de la Mora also refer adolescents to CAIA in cases of sexual abuse.

In spite of a lack of outside funding, CAIA manages to keep the center operating on a part-time basis and attended approximately 700 adolescents in the center since October 2003. These consultations include medical exams and consultations with the psychologist.

PSI/Paraguay

PSI/Paraguay is a local private enterprise that was formed by Population Services International (PSI) with PROMESA (an NGO formed as part of the latter's agreement with USAID/Paraguay that ended in 2001) to work in Social Marketing. PSI/Paraguay is an independent corporation affiliated with Population Services International. It is housed in the same building as PROMESA, and the Executive Director of PROMESA is also the General Manager of PSI/Paraguay. Social marketing revenue generated by PSI/Paraguay's sales of contraceptives and a vitamin product are used to procure replacement stock via PSI/Washington, as well as to fund PROMESA's educational activities.

The contraceptives marketed by PSI/Paraguay include two lines of condoms under the *Pantera* brand – a standard version retailing for G. 3,000 for a pack of three, and a

"super-sensitive" version retailing for G. 4,000 per pack. The former are donated in part by USAID/Paraguay, and the latter are provided by PSI/Washington at a subsidized cost. 30 percent of the USAID-donated stock of condoms are distributed free of charge to high risk vulnerable groups and to NGOs.

In addition to *Pantera*, PSI/Paraguay also markets an oral contraceptive under the brand name of "*Segura*" (retail price of G. 8,100) and an emergency contraceptive pill under the brand name of "*Pronta*" (retail price of G. 15,000). A female condom used to be marketed by PSI/Paraguay but was discontinued due to lack of sales. Youth are one of the target groups for PSI/Paraguay's social marketing products.

According to PSI/Paraguay, *Segura* is the best selling brand of oral contraceptives on the retail market. Nevertheless, sales of *Segura* have plummeted this year from an average of 24,000 cycles/month to 8,000 cycles/month. The reason for this decline, according to PSI/Paraguay, is the widespread appearance in retail pharmacies of USAID-donated oral contraceptives to CEPEP and the Ministry of Health (which are not allowed to be sold in pharmacies), as well as the appearance of contraband oral contraceptives from Bolivia (USAID donations to PROSALUD).

PSI/Paraguay's financial condition is strained at the current time given its lack of direct funding from either USAID or PSI/Washington. It has received short-term financial support from the Bergstrom Foundation and the Conservation, Food and Health Foundation for the launching of *Pronta* ECPs and *Segura* oral contraceptives. In spite of having little income with which to market and distribute its products, PSI/Paraguay had the impressive distinction of being PSI's most cost-effective affiliate worldwide in 2003 as it achieved a cost/CYP of U.S. $2.37.

PROMESA/Arte & Parte

PROMESA is a local NGO formed in 1997. Its mission is to promote health through communication and social marketing. They are dedicated to both reproductive health and maternal-child health and specialize in information, education and communication. As noted under the description of PSI/Paraguay, PROMESA is funded in part by social marketing revenue from PSI/Paraguay and shares the same building and many of the same staff as PSI/Paraguay.

In the field of reproductive health and HIV/AIDS, PROMESA has undertaken many research studies over the years, and produced many training manuals, educational materials, and mass media products. Many of their audiovisual products are now available (with financial support from UNESCO) on eight CD-ROM discs, including documentaries they've produced and highlights of their television show *Con 'S' de Sexo*.

One study concluded this year was a survey of persons living with HIV/AIDS concerning their experience with antiretroviral medications and an analysis of comparative prices of ARVs in the country. This study was undertaken through a program sponsored by CISNI and the IDB.

PROMESA's reproductive health communication activities that are targeted to youth are done under a project called *Arte & Parte*. This project began in 1997 and has included a large array of educational activities including:

- A booklet on teen sexuality entitled *Hablemos Claro Sobre Sexualidad* (Let's Talk Clearly About Sexuality);
- Street drama theatre;
- Weekly radio and television program *Con S de Sexo*;
- Participation on TV and radio shows as consultants;
- "Infosex" news flashes on adolescent reproductive health issues;
- A Web site with a "*Consultorio Sexológico*" that answers young people's questions on sexuality;
- Newspaper columns; and
- Promotional items such as t-shirts, wristbands, and stickers with reproductive health messages.

The target group for these activities has been adolescents from 15-19 years of age in Asunción and the greater metropolitan area.

An evaluation of *Arte & Parte* was done by the Focus on Young Adults Program in 2000. The evaluation concluded, "Overall, the *Arte & Parte* project would have to be viewed as having been successful… The evidence suggests that the project increased the level of knowledge of selected sexual/reproductive issues…The project also appears to have increased the proportion of adolescents who subscribe to certain attitudes/beliefs…"

Partly in response to evaluation recommendations, and partly as a response to cut costs after USAID support ended in 2001, *Arte & Parte* discontinued the television program, street theatre, and "Infosex" news flashes. The radio program continues, however, and the booklet continues to be distributed.

Besides the income derived from social marketing sales, PROMESA received funding from the Swiss Embassy until 2004. PROMESA has received financial support from the Canadian Embassy to develop a video and teacher guide for grades four through six and to train the teachers and sensitize parents so that they support school-based sexual and reproductive health. PROMESA has also been contracted by the *Centro de Información y Recursos para el Desarrollo* (CIRD) for discrete activities. In 2002, PROMESA was also contracted by USAID/Paraguay to develop BCC materials and to conduct a CAP study on reproductive health among out-of-school young in metropolitan Asunción. The BCC materials included a guide for working with out-of-school youth and four videos, which were distributed to NGOs and the Ministry of Health and other groups working with out-of-school youth.

Integrated Adolescent Services (SAIA) — Villarrica

Integrated Adolescent Services (*Servicio de Atención Integral al Adolescente - SAIA*) is located in the city of Villarrica, capital of the department of Guaira and about a three-

hour drive from Asunción. The local chapter of the Red Cross founded SAIA in 1997 after identifying adolescent health and prevention of teen pregnancy as priority health problems. At the time, the center formed part of the Red Cross's *Kuñata'i* project, which supported adolescent health efforts in Asunción and other areas of the country. The Red Cross entered into an agreement with the Ministry of Health to operate the stand-alone clinic that has operated continuously since then.

SAIA aims to be reference center for the entire Guaira department, which has a total population of about 170,000, of which 40,000 are between 10 and 19 years old. Its interdisciplinary team of doctors, nurses, and psychologists offers services to 10-19 year olds from Monday through Friday from 7 a.m. to 5 p.m. and from 7 a.m. to 12 noon on Saturdays. The center, which uses an appointment system, charges G. 5,000 per visit, although waives this fee for many of its poor clients.

SAIA maintains an impressive service statistics and information system which generates detailed records and allows the staff to produce yearly research and evaluation reports used to improve its services and to disseminate its activities to a broader audience. Records show that in slightly more than six years of operation between August 1997 and December 2003, SAIA provided a total of almost 25,000 services, of which about one-third were IEC activities, and two-thirds provision of medical or psychological and counseling services. Pregnancy prevention visits totaled 2,190, about equal to the number of prenatal visits (2,460). The center receives contraceptives free from UNFPA and stocks IUDs, condoms, pills, Depo-Provera, and Postinor-2. Most of the clinical services are for general medical care, a total of 8,440 over the six-year period. Clients wanting HIV testing are referred to local private clinics or to public services in Asunción. The center serves very few adolescent boys.

The center also does outreach with student and youth groups, although community activities such as home visits have been curtailed in recent years with the ending of specific funding for such activities through its agreement with UNFPA. Currently, discussions are underway with UNFPA officials over the possibility of resuming direct assistance in 2005. In 2004, the center held roughly 20 half- or full-day workshops with young people either at the center or in the community. Community outreach efforts currently receive limited funding through the *Educando para la Vida* project, supported by the Spanish Red Cross.

Although established as an initiative of the local Red Cross chapter, the center has always functioned as a collaboration with Ministry of Health and other local institutions. Under its original agreement with the Ministry, the Red Cross maintained the locale and the Ministry provided equipment and staff salaries and training. At one time, the Catholic University supported psychological services and the Municipality paid for part-time doctors. Currently the MOH pays salaries of one doctor, two nurses, a social worker, and an information clerk. The Red Cross contributes services of the center director, two pediatricians, and two Red Cross volunteers. Young people were involved in the center's initial design and, to continue to meaningfully involve youth, an adolescent volunteer forms part of the clinic's management and technical oversight team.

Uncertain funding and difficulties in inter-institutional coordination have prompted the center staff to explore the possibility of establishing themselves as an independent NGO. Such a change would expand funding possibilities and boost continuity and sustainability Reportedly, USAID has encouraged them to pursue this avenue.

Other NGOs working on youth issues, but not directly on reproductive health

Decidamos. This citizen's participation group has a strong youth component

Fundación Marco Aguayo. This NGO was founded in 1992 with the aim of helping improve the quality of life of people living with HIV/AIDS, and promoting healthy life styles through education for prevention, within a human rights framework.

Fundación Vencer. They are a PLWHA group working on ARV access and ending stigma and discrimination.

Grupo Gay-Lésbico Transgénero. Works to defend the rights of gays, lesbians, and transgendered people.

Luna Nueva. Works with girls and young women exploited sexually in prostitution.

Parlamento Joven. Gets youth involved in politics and in policymaking on social issues.

Scouts of Paraguay. Involves boys and girls in educational and recreational activities

Amnesty International-Paraguay. Promotes human rights.

Juventud que se Mueve. Promotes youth participation in public policies and democracy.

APPENDIX 3: SMALL GROUP DISCUSSION RESULTS

A. Group Meeting with Adolescent High School Students in Asunción

Site: La Casona de COOMECIPAR – Asunción
Date: December 2, 2004 – 11:00 a.m.
Participants: Six high school students (one boy and five girls) ages 14-18
Moderators: Ariel González, Guadalupe Romero

The team's two Youth Advisors — Ariel González and Guadalupe Romero — recruited high school students from ages 14 to 18, coordinated the venue for these discussions, oriented the youth on the purpose of the meeting, and co-facilitated the discussions with assistance from consultant Patricia Aguilar. The discussion centered on the needs of youth as they relate to reproductive health and HIV/AIDS and other relevant issues. The following main points emerged from the two-hour discussion:

Communication on sexuality with parents, teachers, and friends. Participants most commonly discuss sexuality with their teachers, and find it easier to talk about the subject with teachers who are under 30 years old. Participants also tend to consult their friends on matters of sexuality.

The role of parents and teachers. Participants strongly agree that parents should talk to their kids about sexuality, starting from when they are very young. However, many parents have difficulty doing so.

Knowledge of and access to contraceptives. The best-known contraceptive methods are condoms, pills, and natural family planning (calendar method). Most participants know about emergency contraception but believe they are only available in large pharmacies and that they are prohibitively expensive for many young people.

Condom use and accessibility. For young people, condom use is common and accepted. However, participants point out that many young people do not know about the correct use of condoms. Most condom use is for pregnancy prevention, not for preventing STIs. Generally, condoms are easy to find and at prices that are affordable to all but the poorest youth.

Premarital sexual relations. Premarital sex is the norm, but a double standard exists whereby it is okay (and even encouraged) for young men but not for young women.

The consequences of adolescent pregnancy. Adolescent pregnancy is something that cuts short school opportunities, and many young women are expelled when they become pregnant. Participants report between three and seven students becoming pregnant in their schools each year.

Mass media messages. Generally, the mass media do not give correct messages concerning sexuality. An exception is condom use, which the media promotes heavily.

Where young people go for reproductive health care. Most young people prefer purchasing pills and condoms at pharmacies. Gas stations are also a popular spot for buying condoms. For many adolescents, buying condoms is an unpleasant experience, because of disapproving comments and attitudes of clerks and other customers. Young people similarly feel uncomfortable buying condoms in supermarkets.

How they view health services. Participants could not name any clinical services specifically designed for young people. They prefer going straight to a pharmacy to ask about or purchase contraception.

The conditions that make health services attractive to them. For the participants, the two most important characteristics of any health services are that they are treated well and seen by a health worker who is relatively young.

Changes that adolescents should make in their reproductive health behaviors. The most important change is to not be so shy about talking about sexuality and to have more respectful discussions (rather than joking or talking about sex in a vulgar way). It is also important for adolescents to be able to resist the pressure to have sex and to be able to say no.

B. Group Meeting with Representatives of Youth Groups

Site: La Casona de COOMECIPAR – Asunción
Date: December 2, 2004 – 2:30 p.m.
Participants: Nine youth (five male, four female) ages 18-23
Moderators: Ariel González, Guadalupe Romero

The team's two Youth Advisors — Ariel González and Guadalupe Romero — recruited young people ages 18-23, coordinated the venue for these discussions, oriented the youth on the purpose of the meeting, and co-facilitated the discussions with assistance from consultant Patricia Aguilar. The discussion centered on the needs of youth as they relate to reproductive health and HIV/AIDS, and how their organization could work to improve YRH. The following main points emerged from the 2-hour discussion:

Communication on sexuality with parents, teachers, and friends. Participants prefer to converse with their friends about sexuality, or with their boyfriend/girlfriend. Some seek information on sexuality from magazines and occasionally from the Internet.

The role of parents and teachers. Parents generally are afraid to discuss sexuality with their children, because they lack the necessary knowledge. This reflects a general

difficulty to openly discuss sexual relations in Paraguayan society. Nonetheless, parents should be supportive of efforts to give their children correct information.

Knowledge of and access to contraceptives. The best-known contraceptive methods are condoms, pills, withdrawal, the calendar and rhythm methods, and herbal methods (*yuyos*). Condoms and pills are easy to obtain and to use. Not all the participants are familiar with emergency contraception, and those who do know about it say many people mistakenly believe the method is an abortifacient.

Condom use and accessibility. Condom use is common and they are easy to obtain. Almost all youth carry at least one. The primary motivation for condom use is to avoid unwanted pregnancy.

Premarital sexual relations. Premarital sex is the norm, although some young people opt for abstinence. Young people tend to use the word "virginity" rather than "abstinence," which is not normally used or understood. A double-standard prevails whereby young men are expected and encouraged to have sex while young women who engage in premarital sex are looked down on. Moreover, young men who abstain are stigmatized as "gay."

The consequences of adolescent pregnancy. The main consequences of adolescent pregnancy for girls are the termination of studies and negative economic impact. Many young men shirk responsibility for children born out of wedlock.

Mass media messages. Mass media is full of messages that promote sex, but also promote condom use. Some of these are fear-based, others are more positive (for example, the radio program "*Con "S" de Sexo*"). Mass media — radio in particular — should be used to reach more young people. Mass media is still underused in the interior and among poor youth and other at-risk groups. Mass media should also promote the sexual and reproductive rights of young people. Moreover, any mass media campaign should be tailored to the Paraguayan reality and not simply transplanted from another country.

Where young people go for reproductive health care. Participants agree that gas stations are the best places to obtain condoms. Pharmacies are good places for pills and other contraceptive methods, although many young people are turned off by the judgmental attitudes of pharmacy workers. There should be condom-dispensing machines in pubs and discotheques.

How they view health services. Participants could not name any health clinics specifically designed for adolescents. They view such services as curative rather than preventive.

The conditions that make health services attractive to them. Clinics should employ workers that are pleasant and relatively youthful; the space should be comfortable and, above all, confidential. Peer education is an important strategy to improve dialogue on sexuality.

Changes that adolescents should make in their reproductive health behaviors. Young people need more information about reproductive health and know how to prevent pregnancy.

How their organization could work to improve youth reproductive health. Participants from various organizations support the idea of expanded peer education on sexual and reproductive health. Also of value would be workshops and conferences on the subject, held within existing institutional structures.

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